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Original Articles.

METRITIS AS AN INITIAL LESION IN PELVIC DISEASE; ITS COMPLICATIONS AND TREATMENT BY ELECTRICITY.¹

By G. BETTON MASSEY, M.D.

THE attractive field recently opened to surgical gynecologists by the discovery that the ovaries and tubes may be amputated without invariably resulting in the death of the patient, has caused an enormous preponderance of current medical literature to be directed toward diseases of these organs. So great has become the furor that little else is heard at our special societies but discussion on the wet specimens thus procured, which are brought in regularly in buckets by certain operators. This singular abundance of pathological material supplied by two organs out of an important group, is calculated to make an on-looker who is, fortunately, free from what might be called the operative infection, inquire carefully into its reasons. Granting the peculiarly peccant nature of these organs as a justification, it may be asked why resort should invariably be had to amputation rather than to a more conservative operation. It may be that there is such a thing as a war-time in this work, when, as in military surgery in the field, parts of nature's handiwork are hastily removed that a more thoughtful conservatism would have restored to health.

But it is not my purpose to discuss at present the debatable questions of the proper management of in-

flammatory conditions of the ovaries and tubes; they are merely alluded to at this time because it is my conviction that many ovaries and tubes have recently been removed when the real seat of trouble was within the uterus.¹ In examining for tender spots by the bimanual manipulation, it is exceedingly difficult to differentiate between a sensitive ovary and a tender uterus, and if one's mind is so constituted that the uterus is entirely ignored, and endometritis or metritis unthought of, a mistake is readily made. One operator declared some two years ago that he did not believe there was such a thing as endometritis. Dragging upon the tender uterus, as he did daily, in his endeavor to find salpingitis, he mistook the purport of the pain excited.

In contrast to this position, it may be affirmed that inflammatory conditions of the uterus are the most frequent of all the local diseases of parous women, and not infrequently found in virgins. More significant still, it may be said to be either the precedent condition or the nidus of many of the most formidable diseases in this locality, such as certain displacements, catarrhal salpingitis, pyo-salpingitis, ovaritis, cancer of the cervix, fibrosis, and many other lesser troubles. How great, then, is the necessity for its early recognition and prompt treatment!

The classical studies of this disease found in the books are most instructive, though the pathological conditions described in the several varieties of endometritis are of but little clinical use to us, since we

¹The grounds for this conviction are derived primarily from a number of cases of post-operative pain seen in private practice and at the Dispensary for Women at Fourth and Spruce streets. Many of these cases had enlarged and tender wombs when seen by me, and had either been made worse by the operation or left in an unchanged condition.

¹Philadelphia County Medical Society, February 10, 1892. Dr. L. K. Baldwin in the chair.

do not often study these cases in the dead-house, and as yet but few specimens have been presented at the societies. Whether the case is one of interstitial, follicular, or polypoid endometritis, it is, moreover, of secondary importance, in face of the present apparently well-founded belief, that they are all examples of that protean disease of mucous cavities—microbic invasion. The several forms of cervicitis, endocervicitis, endometritis and interstitial metritis are clinically distinct and largely separable, it is true, but the fact should not be lost sight of that they are all alike microbic in origin, even subinvolution being septic or trauma septic, and hence are all mere local variations of the same disease.

The recent developments of bacteriology teach us plainly, then, that simple endometritis—a bacterial colonization of the endometrial gland—is the primal step in these progressive conditions. Whether the morbid germ is one of the common staphylococci of pus or some other organism, it seems clear that to its conquest of the local phagocytes is due the hyperæmia, hypersecretion and hyperplasia of the glandular substance of the endometrium, which, later, extends to other situations by either direct continuity of structure or by lymphatic absorption. The reason for the peculiar susceptibility of the uterine cavity to such invasions is easily conceived when we remember that the intra-uterine mucosa is distinctly glandular—that the endometrium is, in fact, a gland rather than a mucous membrane.

The method by which the uterine cavity becomes the culture-medium of these infections deserves some consideration. On reviewing the conditions present, particularly the ubiquity of pus-germs in the centers of population, one is disposed to ask why an infection of this region is not universal instead of the exception. The natural, healthy mucus and the temperature would seem to be an ever-present invitation. Why, then, are germs normally absent above the internal os, though so abundant below that point? The answer has never yet been given; but it can be none other than that of a body of sentinel phagocytic cells stationed in the cervical cavity to war upon morbid germs. Remove these sentinel cells, or lower their vitality, and the resistance they present is overcome by the outer hordes.

The ineffectiveness of these vital sentinels in puerperal infection is manifest. By a flank movement or brutal charge the seeds of destruction are planted well beyond the lines. An endometritis results, which is the cause rather than the effect of the subinvolution of the muscular fibers. In the nulliparous, and particularly in virgins, the method of invasion is not so clear, though we do not have to look far to find it. The prevalence of early stages of metritis—in other words, of endometritis—in perfectly pure virgins is a daily result of my inquiries. At sixteen, seventeen, and particularly between seventeen and twenty-three, in this climate, a uterine leucorrhœa is by no means uncommon in weak and delicate girls; and we do not have to adopt the harsh and generally untrue statement of Schroeder, as quoted in the most recent work on this subject, Pozzi's *Gynecology*, that the germs are introduced by masturbation. The condition of the general health of these patients is the real causal factor. The germs are always in the cervix normally unless the hymen be imperforate, and they are enabled to penetrate within the uterine cavity by reason of weakness on the part of the sentinel cells. A girl whose blood is impoverished by inherited weakness, to which is added the many imperfections in our methods of

fashionable education, is in but a poor condition to marshal sentinels and defences against any morbid attack. The logic of this view is sustained by the methods of many rational physicians in dealing with this condition in such cases. Let the blood-making organs once be restored to health, and the invaders, *if not too deeply intrenched*, will be driven out.

At its inception this affection is usually subacute, if we except the more virulent forms of puerperal metritis, and runs its course without material disturbances of temperature, like the analogous affections of the nasal cavity. Even after the disease has extended so far as the Fallopian tubes, with the production of muco-purulent accumulations, the temperature may still be normal. In my experience, an acute stage is lacking, the onward march of the affection being as insidious as it is gradual. Beginning as an endometritis or endocervicitis, the patient is only conscious at first of a leucorrhœa which becomes more abundant and irritating to the vagina and vulva, and should be the sign for active and intelligent interference on the part of her physician, though of late a do-nothing policy has been advocated by some. It has been said by an eminent authority that the womb has its natural secretions, like the nose. That is, of course, true, but it should be remembered that the nasal secretion is not normally muco-purulent; as soon as pus-corpuscles habitually occur in either secretion, the existence of a diseased condition is manifestly proven.

The subsequent stages and the effects of this catarrhal endometritis are natural consequences. Accompanying the hypertrophy of the endometrium into fungoid and cryptose conditions, we have a direct stimulation of the connective-tissue cells of the parenchyma. Trophic changes in this situation and general fibrosis of the body of the uterus result. Coincidentally, or at a later period, an extension upward along the mucous tract occurs, and salpingitis, ovariitis, or both, add their burdens to the suffering woman. I shall not recount the local symptoms of this conglomerate affection, beyond the statement that at various periods in its course we find changes in the quantity and quality of the secretions, erosion of the os from irritating discharges, hypertrophy and tenderness of the cervix and corpus, combined with a reasonable movability of the uterus as a whole. With these facts you are all familiar. On the reflex symptoms some doubt has been thrown of late, but the best proof that pains down the limbs, in the abdomen, and in the back, with or without nervous prostration, are caused by this "irritable" uterus, is given by the disappearance of such symptoms as a result of local treatment. The reason for the doubt lies in the lack of neurological training in many gynecologists, who have mistakenly treated such diseases as hysteria, neuralgia, lateral sclerosis, and locomotor ataxia as mere nervous manifestations of pelvic disease. I have elsewhere reported an instance of removal of the ovaries for pains that were due to an aggravated spastic condition; and the physicians that follow my service at the Spruce Street Dispensary recently saw an even more ludicrous error of a well-known colleague: A woman applied for the relief of a pain in the side, in the region of the floating ribs, making the statement that she had been under treatment for it at a neighboring dispensary for several years. The treatment had been directed entirely to the pelvic organs, and much pressure had been unsuccessfully brought to bear on her to consent to a removal of the ovaries. In spite of this treatment her pain was somewhat worse. In glancing at her back I was led to request that the corsets be removed, which revealed

a most marked case of scoliosis, with corkscrew twist of the vertebræ. A properly-fitting brace gave her complete relief from pain. Even a slight acquaintance with orthopædics would not hurt gynecologists; an elementary training in neurology is certainly essential to correct diagnoses in this specialty.

Besides errors of diagnosis, it is possible that the present tendency to minimize the effect of uterine disease in causing backache and other neuroses is due to the failure to cure such conditions by removing scar-tissue from the cervix. Failing to cure these cases by cutting out this harmless reparative effort of nature and by removal of the appendages, the remainder of the woman is kept in bed for long periods of time, under the theory that the rest-cure was the proper thing after all, and that rest was the most essential part of the rest-cure.

Clinical proof of the dissipation of these baneful symptoms by the use of means that combat the initial microbic affection and its nutritional and hypertrophic consequences is the best proof of their correlation.

A recent case will, I think, present this proof in a strong light. A healthy young lady fell a short distance from a hammock, striking the end of the spine. She suffered immediate pain, and two weeks later applied to an intelligent gynecologist, who treated her for retroversion, and later for inflammation of the ovaries, so far as could be ascertained from the patient. After some early relief the condition became stationary. At this time the case was seen in consultation by Dr. Baer, of this city, with a view to removal of the appendages, which was, however, not done, for some reason. Sixteen months after the beginning of the disease the patient entered my private sanitarium in the following condition. Subjective symptoms: continuous, deep seated scratching pain about an inch and a half above each ovary; a tender pain in the sacrum, and an inability to walk more than two squares without an intensification of these symptoms and great prostration. Objective symptoms: external evidences of perfect health, marred only by coldness of the extremities. Internal examination showed considerable leucorrhœa; uterus apparently small and in normal position, but when elevated on the finger in the posterior cul-de-sac extremely painful. Thinking the case one of posterior parametritis or ovaritis, she was treated by the vaginal galvanic method, in conjunction with general electricity and massage for the incipient nervous prostration that was becoming manifest. Considerable improvement resulted, but no headway was made with the peculiar pain in the ovarian regions until it was recalled that nothing had been done directly for the endometritis. The sound, now passed for the first time, showed that the apparently small uterus had a cavity exceeding three inches. An intra-uterine positive application was therefore made, of a strength of 20 milliamperes, and this had the happy effect of checking the so called ovarian pain permanently. Four subsequent applications of the same kind were made for the control of the discharge, and the patient was restored to health and has remained well now for some time.

This patient had been kept for three months on a lounge by her previous attendant, under the theory that this supposed essential of what is called the rest-cure would be of service. Shorn of its institutional control and electricity this fashionable mode of treatment is a two edged sword that is responsible for more than one case of chronic invalidism. Used with such essentials, including direct electrical applications to the uterus in the class under consideration, these

cases in the borderland between the domains of gynecology and neurology may be permanently restored to health, though he who essays but one part of the treatment will meet with frequent failure and disappointment.

For therapeutic purposes cases of chronic metritis are divisible into two classes that much resemble the divisions made by the late George M. Beard in cases of sexual neurasthenia in the male. In the one class the affection occurs as a purely local disease, the nervous organization of the individual being so robust that it fails to become affected by the local disturbance; in the other class a far less degree of local trouble may be found associated with profound depression and disorder of the nervous system—a disorder that seems greatly disproportioned to the local disease.

The treatment of the first class of cases is naturally entirely local, and may generally be carried out in the office, when the disease has not yet ascended to the tubes and ovaries. Various modes of treatment have been efficaciously employed, though many are now abandoned as either ineffective or dangerous. I shall limit my remarks to the local use of electricity, first prominently brought forward by Apostoli, whose conclusions have been more than confirmed by my own experience. As in other subacute microbic affections of the glandular membranes, the galvanic current presents a typical alternative action which may be brought to bear directly upon the diseased surface, and by means of applicators that are in themselves innocuous because elastic, easily inserted, and lacking the dangerous piston action of the cotton swab. The contrast with acids or other cauterants that must be inserted by force is very great; no hooking or pulling on the cervix or other harsh methods are necessary, and the local action is, moreover, strictly mensurable and controllable. By reason of its greater antiseptic effect the positive pole is usually preferable, though in the later stages of the disease, when the endometritis has eventuated in a hyperplasia, the galvanic alternative method is better than the use of a single active pole. In subinvolution, particularly, the alternative galvanic method within the uterus is quickly curative, accompanied at each treatment by a primary faradic application.

Judging from results, the local electrical treatment seems to act in a threefold manner, each special element of the method varying in usefulness in different cases. One part of the action is a local alternative effect on the endometrium; another results in a quickened absorption of hyperplastic tissue, and still another in stimulation of the muscular fibers to immediate contraction and increased tone. The first action is most important in fungus and hemorrhagic cases; hence, the positive pole should be used alone, with a duration of some minutes at each application. As the possibility of causing an immediate increase of muscular tone in the uterus increases, the alternative method becomes more valuable; and in recent subinvolution the faradic current alone is usually sufficient.

If, at the initial examination of a case, a reasonable doubt is present as to the preponderance at that time of the original metritic trouble or of a secondary extension into the tubes and ovaries, the intra-uterine method should be preceded by a more or less prolonged vagino-abdominal galvanic treatment; and in these cases, as well as in the second class here described in which the nervous system is affected, the value of institutional treatment is enormous. By a combination of internal and external electrical treatment, massage, diet, and partial rest, these cases can

be almost invariably restored to health, unless pus-cavities have formed—an event that is much rarer than some would have us believe. It may take weeks to accomplish these results, it is true; but it is also true that it takes years for the patient to recover health after the performance of a castrating operation.

212 SOUTH FIFTEENTH STREET.

CHRONIC ENDOMETRITIS.¹

By J. M. BALDY, M.D.,

Professor of Gynecology in the Philadelphia Polyclinic; Surgeon to Gynecæan Hospital; Gynecologist to St. Agnes' Hospital.

OF late years it has become the habit of gynecologists to consider almost all endometrical disease as symptomatic, and not an independent lesion. It is certainly true that many pelvic diseases are accompanied by an unhealthy condition of the endometrium; especially in pelvic inflammatory disorders the lining membrane of the uterus is so frequently affected as to have given rise to the supposition that it is either caused by the pelvic disease, or rarely occurs independent of it. In fact, such assertions are frequently made in print and on the floors of our societies. The temptation is strong to accept this theory, which appears at first blush to be so plausible, but which is, nevertheless, most fallacious. My daily experience is teaching me that endometritis as an independent disease is quite a common disorder, and is at the bottom of many of the discomforts suffered by women. The causes giving rise to this disease are much the same as those which originate vaginitis, and particularly salpingitis—specific infection and post puerperal sepsis being the most prolific, and giving rise to the bulk of the cases. Oftentimes the beginning of the trouble can easily be traced to a child-birth or to an abortion. The woman has had a slow get up, and will give the history of some fever, or she has regained her usual health very slowly, and possibly not at all; she will have complained of a vaginal discharge since her confinement, when previously she had been free from this annoyance. The history may be that of an attack of specific infection. Sometimes the history in such a case is clear—a sudden appearance of a yellowish vaginal discharge, with swelling of the labia and burning micturition. At other times the evidence of specific infection is not entirely satisfactory; but it is quite notorious that women often become contaminated without giving it any particular attention, or the discomfort has been so slight as to be soon forgotten. In any event, if the disease be neglected and spreads to the cavity of the uterus, it soon spends its force and settles down to a chronic condition. It may or may not extend into the Fallopian tubes and cause a salpingitis and peritonitis. Should it do so, as is often the case, the removal of the appendages will not necessarily bring about a cure of the patient. In fact, this is the secret of the failure of laparotomy in many of the cases which are going from one clinic to another for relief. Even if the disease is complicated by pelvic disorders of an inflammatory nature, especially if the two arise from the same cause, it is well to first turn our attention to the endometritis, in which case a laparotomy may at times be avoided. In other words, certain cases, embracing the two diseases, the symptoms from the endometritis may overshadow those from the salpingitis; this is especially true of many instances in which the intra-peritoneal damage has not been very

serious. In those cases where the intra-peritoneal inflammation has subsided, and only its products remain, the treatment of the endometrial inflammation, which, under these circumstances, is usually chronic, can be carried out with impunity if ordinary care be taken. Of course, in the event of there being an acute, or even a subacute, pelvic inflammatory condition present, great care must be taken not to interfere with the uterus in any way, else an already bad condition of affairs may be made much worse, and even serious.

In many patients, in whom there exists post puerperal septic endometritis or specific endometritis, the disease has stopped short of the tubes, and has not involved either them or the peritoneum. These cases are quite common, and are daily overlooked. The women wander from one doctor's office to another, and, finally, when their money is all gone, into the public clinics, seeking relief in vain. It is often a matter of surprise to me that many of them have never even had an examination made; but have been treated for months and years with drugs, or have been advised to use an injection of hot water. The hot water injections as usually given are worse than useless. Just sufficient water at a moderate temperature is used to cause a congestion of the uterus and pelvis, which congestion is not relieved by the secondary effect of the hot water, viz.: the contraction and consequent driving away of the blood from the parts. These women suffer from a continual uterine discharge more or less profuse; there is, perchance, a feeling of weight and heaviness in the pelvis, accompanied by backache; sometimes they feel weak and worn-out. The menstrual function is disordered, being generally irregular and profuse; pain may or may not attend this function. These symptoms exist either alone or in various combinations, the only constant and reliable one being the uterine discharge. A local examination discloses an enlarged and heavy uterus, from the cervical canal of which an unhealthy thickish discharge is oozing. Oftentimes the cervix is eroded, and the mucous membrane of the everted lips, if the lips be everted, bleeds on being touched with a piece of cotton or an instrument. This hemorrhagic condition is more apt to be present when the disease is still acute or subacute; but, nevertheless, it is at times seen in the chronic cases. In some instances the uterine body is comparatively normal to the touch so far as its consistency is concerned; again, it may be either too soft, or, what is more common, extremely hard, and even almost fibrous in character. These changes indicate that the disease is not altogether confined to the endometrium, but has invaded the structures comprising the uterine wall. It is no uncommon thing to see an endometritis and a metritis co-existing; in fact, in chronic cases it is rather the rule than the exception. The disease is almost always primarily an endometritis, and treatment which will cure this affection will be followed by a cure of the metritis almost as a matter of course. So much is this the rule that I have gotten to look on these two diseases as very much one and the same.

Where this condition of affairs exists—a large and abnormally heavy uterus—there is very apt to be a retro-displacement of the womb sooner or later. Whether or not all displacements which give rise to trouble are originally caused by uterine inflammations, it is a curious fact that it is a very rare thing to find a troublesome retro-displacement without either uterine or pelvic inflammatory diseases complicating it.

¹ Read at the Philadelphia County Medical Society, February 10, 1892. Dr. L. K. Baldwin in the chair.

For the treatment of uncomplicated endometritis and metritis there are a variety of remedies, some of them quite effective, while many of them are useless, and are applied in a haphazard way. My own preference is to adopt the shortest and surest course of procedure. The woman is put under ether, the cervix is dilated, and the uterus thoroughly curetted; the uterine cavity is then washed out, and an application of Churchill's iodine made to its surface. If there is pretty free bleeding in consequence of these manipulations, the uterus is packed full of iodoform gauze, which is removed in the course of a day or two, as circumstances demand. Ergot may or may not be given by the mouth, the indications for its use being hemorrhage or an enlarged heavy uterus. Usually, I give a half drachm of the fluid extract three times a day for a short period, gradually reducing the quantity until it is dispensed with altogether within about a week.

As to the steps of the operation: The patient is placed in the dorsal position, the dilatation is made with the Goodell rapid dilators after careful antiseptic precautions. I dilate usually only sufficient to introduce and manipulate my instruments easily—from three-quarters of an inch to an inch. Great care is taken to make the curettement a thorough one. All debris can be washed away, and the cavity cleansed by the use of the rectal nozzle of a Davidson syringe. The application of iodine follows immediately, it being applied with a long nozzled uterine syringe. The patient is now returned to bed, and nothing more is done for a week or two, excepting to give absolute rest, hot water injections, and keep the bowels soluble, together with the ergot as indicated. I have not found occasion to place a hand rubber drain in the uterus, as Wylie does, nor to pack it with iodoform gauze for a prolonged period, as Polk proposes. I find, if my dilatation has been properly made, that the cervical canal remains sufficiently patulous for the necessary drainage. The uterus will resent in one way or another the presence of a foreign body, and these procedures can only result in just so much more irritation and consequent discharge.

Some patients are cured altogether by this treatment; but, for the most part, in order to secure a thoroughly satisfactory result, treatment must be kept up for some little time after the woman is allowed to get out of bed. It is my habit, in these cases, to make an intra-uterine application of iodine about twice a week for a few weeks, then once a week, and finally to withdraw the treatment altogether; the hot water injection should be kept up twice a day throughout the whole course of treatment. It is not uncommon, where the endometrium has undergone a fungoid change, for the disease to return, and the whole treatment has thus to be gone through with a second time.

Many patients will not submit to this treatment, in which event it becomes necessary to resort to other methods of management. A prolonged course of intra-uterine treatment will, in many cases, eventually bring about the same result. I do not maintain that iodine is the only remedy to be used for this purpose, but I have come to use it routinely for the reason that I have found no other drug which would give better results. It is not advisable always to use it in full strength, in which case it may with advantage be diluted with glycerine in the required proportions. Ichthyol and all similar substitutes have only proven disappointing.

So much for the uncomplicated cases of endometritis. Where the disease is accompanied by a pelvic

inflammatory condition, the first question to settle is, whether or not an abdominal section is to be performed for the removal of the appendages. If they are not sufficiently affected to call for the operation, and if the uterine symptoms predominate, and are very annoying, I have no hesitation in treating the uterine cavity. A long-nozzled uterine syringe may with safety be passed into the uterus, even in the presence of considerable pelvic disease, and a local application thus made. In these cases the strength of the material injected should be regulated by the amount of inflammation, as a strongly irritating fluid will be much more likely to cause trouble than the mere passage of the instrument itself. When the pelvic disease has been an old one and quiescent, I have not hesitated in gently dilating the cervix and curetting the cavity of the uterus, nor have I ever had any trouble follow such a procedure. In this class of patients there is an opportunity for the nicest kind of judgment, and if one be skilful and careful in selecting the proper cases the treatment may be followed by the greatest benefit. I am perfectly well aware that this is contrary to the teachings of many gynecologists of the present day, but my own experience in these matters has opened my eyes to the fallacy of such ideas. If the gentlemen opposing the practise of intra-uterine treatment would try it on some of their cases who continue to have enlarged uteri and a vaginal discharge after the removal of the appendages, they would soon become convinced of its practical value, even in these cases.

The treatment of endometritis by electricity I have not touched upon, not that I do not approve of it, but because Dr. Massey follows me with a paper on that subject. It is especially valuable in those cases which refuse the above line of treatment.

DISCUSSION.

DR. JOHN C. DAcOSTA: I think that cases of pure acute endometritis are rarely seen. The cases that I generally meet with are chronic cases in which there is metritis in combination with endometritis and hyperplasia of the uterus. The treatment of acute endometritis should be as different from that of the chronic cases as that between an acute inflammation of the eye or legs and a chronic inflammation of them. In the acute, as well as the chronic form, injections are of much value. The reason that injections often do not benefit is that they are not properly given; they should be given with the woman in the recumbent position, in such a way that the water will reach the neck of the womb and distend the vagina, opening out the folds in the anterior walls and washing away the poisonous discharge. In order to do this the patient should be instructed to keep the vulva closed with the fingers of the left hand until the vagina is filled and distended, and then allow the water to escape. This process can be repeated as often as necessary. In chronic cases nothing will do more good than a good free bleeding. Three to five ounces of blood should be taken, and the woman will often get up off the table with all the pain gone. Another good plan of treatment is by the thermo-cautery burning a hole one-quarter of an inch deep into the cervix. Ten days after such an application the uterus will look entirely different. Dr. Baldy's method of treatment by dilatation and curetting in these chronic cases is one I have used for years, and is of value; for these uteri often have diseased membrane and fungus granulations, keeping up a continual irritation, which the scraping will relieve by removing a cause of irritation and setting up an acute inflam-

mation instead of the chronic one. I should rather hesitate to follow Dr. Baldy's plan of injecting tincture of iodine in the uterus. I think a safer way is to take a piece of cotton in the dressing-forceps and swab the whole surface with the preparation of iodine. If you use such a preparation as I do, twice as strong as Churchill's tincture of iodine, you will find that there is very little hemorrhage. The preparation which I use is one part of iodine, two parts of iodide of potassium, and four parts of glycerine. This will cause a decided contraction of the uterus; if it does not, give ergot in doses of a teaspoonful every hour until the bleeding stops. I do not like the idea of tamponing the uterus. I do not think that it is necessary; it is better to stop the bleeding before the patient is left.

DR. CHARLES P. NOBLE: Dr. Baldy's paper discusses a very important subject, and one upon which every practitioner of experience has decided views. Concerning numerous special statements in the paper, there is a general concurrence among gynecologists; but in my judgment the general teaching of the paper is not sound, and if allowed to go to the general practitioner for his guidance, I feel certain that evil results will follow.

It seems to me that Dr. Baldy has gone back ten years to the point where gynecology was when I was a student; and not only are we led backward, but are given no good reason therefor. A word with reference to pathology: A mere discharge from the uterus does not indicate endometritis. We are indebted to Dr. Emmet and others for disproving the idea that every uterine discharge indicated endometritis. This may come from various constitutional derangements, such as a feeble heart, general debility, phthisis, constipation, or a sluggish portal circulation, and if these are remedied the discharge will disappear. This class of cases must be eliminated strictly when discussing endometritis. Some even go so far as to deny that there is such a disease as endometritis. I have not studied the endometrium microscopically; but clinically I believe that there is endometritis. Another important point in the study of endometritis from the therapeutic standpoint is whether the disease is or is not complicated. Treatment which is beneficent in uncomplicated endometritis may be and is dangerous where complications exist. Endometritis is often the forerunner of salpingitis, which is the forerunner of peritonitis. Old chronic peritonitis cases generally have endometritis. We also know that cases of uterine fibroid often have endometritis. It is apparent that the treatment of such cases should be essentially different from the treatment of uncomplicated endometritis. Where the endometritis is uncomplicated, I think the treatment directed to the uterus is moderately safe, although even here we may produce complications from intra-uterine applications, and especially from intra-uterine injection. The experience of our predecessors has proved this, and has shown that most cases of endometritis can be cured without treating the endometrium directly. I have supposed that we had heard the last of intra-uterine injections. In the hands of our teachers the practice was found dangerous and was given up. When the cervix is dilated widely, as after curetting, the danger is probably slight; but when done in the office without such dilatation it is distinctly dangerous—how much so any old book on gynecology will prove.

I regret that the limited time allowed for debate will not permit me to discuss the subject further; but it seems to me that the points presented are very vital ones, and that they have been neglected by Dr. Baldy.

DR. M. PRICE: I thank God that I am not a woman, if a woman is to be treated in this way. The question has often been asked, Why is it that we have so much pelvic trouble? I say that the paper to-night answers that question. Every sort of acid and application has been forced into the uterus. It has been burned by the hot iron. It is no wonder that we have endometritis. Why should we not have endometritis with complications extending to the other organs and to the pelvis, requiring removal of the diseased tissues? The same men that advocate this treatment admit that they have had to remove the appendages a few weeks after dilatation.

DR. BALDY: The treatment which is so vigorously denounced referred simply to uncomplicated endometritis, not to endometritis associated with fibroid tumor or pus tubes, or any other serious pelvic or abdominal disease. I should treat these troubles as the occasion called for. Where endometritis is uncomplicated, it can be dealt with without the slightest possible bad effect. My cases are put to bed and kept there until safe from all inflammatory trouble. Intra-uterine injections can be made in one's office with impunity if done carefully. The cervical canal in some of these cases is so patulous that it would admit a tube twice the diameter of the nozzle of the syringe. I use the syringe almost daily, and have not the slightest trouble from it.

Dr. DaCosta spoke of scarifying and curetting to produce bleeding. The curette in my hands generally produces that effect. If the bleeding is moderate I do not use ergot. When I use ergot, I give it in fair doses to produce contraction of the uterus. I select the cases which I subject to the treatment described, and I care not if I have gone back ten or twenty years if the treatment brings about the desired results safely. I am continually receiving patients on whom abdominal section has been done, in whom the uterus is large and heavy, and all the old symptoms remain. I scrape the uterus and remove a large quantity of *débris* from some, and in many this gives relief.

SUCCESSFUL TREATMENT OF MEMBRANOUS CROUP WITHOUT EITHER TRACHEOTOMY OR INTUBATION.¹

By JOHN B. TURNER, M.D.

THE class of cases to which I refer are of laryngitis with fibrinous exudation and not complicated by diphtheria. My experience before February, 1891, covering a period of nine years, was to have treated medicinally eight cases, six of which died, showing a mortality of 75 per cent.

The results of tracheotomy in the practise of my medical friends having been so unpromising (all the patients dying), I did not at any time see fit to have the same tried in my practise. As to intubation, my experience is small—two cases, both dying. I condemn tracheotomy and intubation in true croup, as the same objections obtain in both, viz., that the accumulation of muco-pus in the lower part of the trachea and in the bronchi is lost sight of. Paralysis of the posterior crico-arytenoid muscles, preventing dilation of the glottis in inspiration, is a symptom no doubt relieved by tracheotomy and intubation, but the other paramount elements of danger in the case, as pneumonia, capillary bronchitis, accumulation of muco-pus, feeble expiratory efforts preventing ex-

¹ Read at the Philadelphia County Medical Society, February 10, 1892. Dr. L. K. Baldwin in the chair.

pectoration, due to general debility and exhaustion, are unremedied.

The treatment I have used since February, 1891, is based upon the allaying of inflammation about the site of the membrane, effecting the separation of the membrane, lessening the formation of new membrane, effectually controlling laryngeal spasm and sustaining the strength. I use asafetida by suppositories to allay spasm and to give needed intervals of quiet, restful sleep and consider it a valuable and much overlooked remedy in membranous croup.

For the other conditions or symptoms I used ammonium chloride given in syrupy mixture without water, as the addition of water makes it unpalatable to children.

In Wood's *Reference Handbook*, in an article written by Dr. Nickles, of Cincinnati, "Wibmer found a very decided increase of the bronchial mucus after hourly doses of eight to fifteen grains of ammonium chloride, and other careful observers noticed the same effect. Experiments of Rossbach seem to show a different mode of action. Under the influence of the salt, the tracheal mucous membrane became anæmic and the secretion of mucus gradually ceased. The utility of ammonium chloride in catarrh of the air-passages may therefore depend upon a favorable modification of the vascularity of the mucous membrane, not merely upon a change of the quantity of the secretion." I am of the opinion that Rossbach's view is the more probable one regarding the action of ammonium chloride, and will better explain its beneficial action upon the catarrh accompanying croup.

I will now give the details of the treatment pursued in my last four cases, and advocate it as one simple, humane, and easily applied.

CASE I.—On February 16, 1891, I was called to see Sallie B., aged eleven months, who was suffering from a severe attack of membranous croup. The mother had lost two children on former occasions by the same disease, one in twenty-four and the other in thirty-six hours. Why croup has a predilection for certain families, I am at a loss to know.

I had the child taken to the Children's Hospital, and Dr. Samuel Ashhurst confirmed the diagnosis and recommended tracheotomy, which was refused by the mother. When the child was brought from the hospital to her home I gave the following treatment:

- R.—Ammonii chlorid. ʒi.
Syr. toltan. fʒij.
M.—S. Half a teaspoonful every two hours.
- R.—Asafetide pulv. gr. xvi.
Quinina sulph. gr. iv.
Codeina. gr. ½.
Olei theobromæ. gr. cxxx.
Fiat suppos. No. viii.
M.—S. One every four hours.

The child did well (the attack lasting eleven days) and recovered. The patient received whiskey and milk at regular intervals, and was kept in a well-ventilated room. By this treatment the appetite remained fairly good, and the strength was sustained. The same child had another attack on December 18, 1891, and by the same treatment was restored to health. I call this second attack Case II.

CASE III.—John D., aged eighteen months; attacked on August 26. Same treatment, and child recovered on the eighth day. The mother poulticed this boy on chest and over trachea, of which action I approved.

CASE IV.—Harry J., aged two and a half years; attacked March 6. Disease lasted one week. Recovered by means of same treatment. This case re-

ceived larger doses of the ammonium chloride mixture because of his being older than the other children.

There was no atomization used on these cases.

DISCUSSION.

DR. EDWIN ROSENTHAL: It seems to me extremely strange that such a disease as membranous croup should be so easily remedied by muriate of ammonium and asafetida suppositories. In a series of some four hundred and twenty odd cases which I have followed and studied, in my own practise and in the practise of my friends, which were not treated by incubation or tracheotomy, and in which the diagnosis is undoubted, but three recovered. In sixty-four cases that I have intubated, fully one-half died. Many of these cases had been previously treated by muriate of ammonium and also by chloral, which I consider a better antispasmodic than asafetida. Chloride of ammonia has been long used in this disease. It was recommended by Dr. Condie—one of our earliest members—for membranous laryngitis, and in *Watson's Practice of Physic*, edited by Condie, was described the method of its action, which, if I remember correctly, was to defibrinate the blood, prevent the pseudo-membrane from forming, and facilitate the absorption of tissues already formed. If Dr. Turner considers membranous croup one disease and diphtheria of the larynx another disease, he falls into error regarding treatment. If he means to say pneumonia, capillary bronchitis and oedema of the lungs, which are so often complications of croup, succumb so easily to the treatment by muriate of ammonia, or that they will not occur when cases are treated in this way, he places himself also in error. I have seen so many fatal cases of croup that I cannot believe that true membranous laryngitis can be successfully treated in the manner he describes. I have practised intubation over one hundred times, and have had fairly good success. But I have not relied upon remedial measures such as have been mentioned.

DR. M. O'HARA: The easy cure of cases supposed to need tracheotomy can bear a very different explanation. It may well be, in view of the many cases of recovery after the apparent judicial condemnation of the doctor, for not depending sufficiently upon the powers of nature.

Some years ago I reported a case and published it in the Proceedings of the County Medical Society, which can be referred to for details (vol. i. p. 21), entitled "Remarks on a Case in which the Necessity for Tracheotomy was Averted by the Systematic Action of Intense Cold Exciting Forcible Inspiration." This was a case in which a most eminent throat specialist considered the time gone by for success by tracheotomy, in a case of nasal diphtheria after measles, and considered it would be closed by death in eight hours, and yet it recovered under use of ice, and he frankly told the mother afterward that he probably would have finished the case with the knife. Here there was an error of judgment; though all thought there was membranous deposit, there could not have been any. I have known similar cases, and sending for a consulting surgeon in several cases, waiting brought the patient around. The late Dr. Henry A. Smith related at one of our meetings many cases of this kind in a discussion on the topic, and I hope those of us present, familiar with the point, will relate such cases for instruction. I rise to have this point specially ventilated.

DR. H. R. WHARTON: I agree with Dr. Turner that many cases of croup get well with the simple

medicinal treatment, but I disagree with him in regard to the large number of unsuccessful results from tracheotomy and intubation. My experience with tracheotomy is that even in the most urgent cases, many recover. Last year, at the Children's Hospital, 43 per cent. of the tracheotomies recovered. I have used chloride of ammonia to some extent in the treatment of croup, but in the last few years I have put more confidence in the carbonate of ammonia, and follow the plan of treatment suggested by Mr. Parker, an English surgeon. I combine the carbonate of ammonia with syrup of senega. My routine treatment in ordinary cases of croup, in which the symptoms are not sufficiently urgent to call for intubation or tracheotomy, is to place the patient on carbonate of ammonia with senega, and to see that he is thoroughly stimulated. At the same time I believe that local treatment by inhalation of some medicated vapor is of service. I have recently employed the ordinary steam atomizer, in which I use an alkaline solution, such as carbonate of soda and glycerine. The atomized solution is used as frequently as every half-hour or hour, according to the urgency of the symptoms. This solution is also useful after intubation or tracheotomy. I believe that many cases of croup do get well if carefully treated, and do not come to the point where operation is necessary. I think that the use of strychnine and digitalis in the early stages of the disease often prevents trouble later on from cardiac failure. While at times these very urgent cases will get better without operation, yet in my experience this is the exception. Within a year and a half, death has occurred in five cases of croup in which I was summoned to do intubation or tracheotomy, before I could reach the patient. I think it unwise to say that in these urgent cases that operation should be postponed, for many cases of croup die suddenly.

DR. B. TRAUTMAN: We should not lose sight of the distinction between catarrhal croup and membranous croup. Most cases of catarrhal croup will get well without much treatment. By keeping the patient warm and giving an emetic, the cure will be effected. In membranous croup the tendency is to postpone operation too long, till cyanosis sets in, and then the patient generally succumbs. The course of treatment which I pursue in membranous croup is the administration in one mixture of bichloride of mercury, tincture of iron and chlorate of potassium. As an emetic I give sulphate of copper, one grain for each year of the child's age. That will often bring away the whole membrane. If it does not bring it away, tracheotomy or intubation should be done at once.

DR. NUTT, of Williamsport: This subject has interested me very much. For the last eight or ten years I have done intubation frequently—I think in seventeen consecutive cases—and out of that number there has been only four deaths. I am therefore a strong believer in intubation, and I had hoped that there would have been a more general discussion on this point. I fully agree as to the necessity for intubating early. When I first began the use of this measure, I usually put it off until the last moment, as a last resort. When the lungs are all filled up and the child cyanotic, I do not believe anything will save the child. I cannot see that intubation has any bad effect, and if used early in the disease we can reduce the rate of mortality very greatly.

DR. JOHN B. ROBERTS: It seems to me that this is the old story, that the man who never operates is sometimes wrong, and the man who always operates

is sometimes wrong. The discussion seems to be a little uncertain because some speakers use the word croup and others the word diphtheria. Whether or not they mean the same thing I do not know. If I am called in surgical consultation to a child with difficult respiration due to some inflammatory disease of the throat, it makes little difference to me whether some pathologists call it croup and some diphtheria. I call them all diphtheria, and advise the attending physician to report the case as diphtheria to the Board of Health. Eight or ten years ago I made up my mind that in all cases of diphtheria where there was dangerous difficulty in respiration, my duty was to advise tracheotomy, and to do it. That was before the time of intubation. I did tracheotomy over and over again, and, though I never saved a patient, the relief to the patient was so great that I never regretted the operation. I believed that in all such cases, where there was dangerous cyanosis, my duty was to open the trachea. Since intubation has been revived by Dr. O'Dwyer, I have adopted that as the primary operation, and reserve tracheotomy for a later procedure. To see a child suffocating to death and withhold your hand, is almost as bad as saying that you will not use the stomach pump, even though you know that the person has poison in the stomach. Of course, I do not advocate intubation or tracheotomy in cases where the child is dying from the diphtheritic poison and not from obstruction in the larynx. A few weeks ago I was called in consultation to see a child. The case had previously been seen in consultation by another gentleman, who said that nothing could be done. I was then called and introduced an intubation-tube, and in a few minutes the child was breathing comfortably. The tube was vomited out, however, but the relief which he had experienced was so great that the child permitted me to apply the tube again without struggling. He subsequently wore the tube about two days, and is now well. We must select our cases for tracheotomy and intubation, just as we select our cases for laparotomy or any other operation.

DR. JOHN C. DACOSTA: It is not strange that such brilliant surgeons as the last speakers advocate tracheotomy. But what is the mortality? Some ten or more years ago I collected and analyzed twenty-four or twenty-five hundred cases of tracheotomy, and the result showed that only about 24 per cent. recovered. But one reference has been made to night to the old-fashioned method of using emetics. Nothing will dislodge the membrane quicker in croup than an emetic. You may use ipecac or sulphate of copper, but one of the best is the yellow sulphate of mercury, which latter, I think, has more than a simple mechanical effect. In true croup there is nothing equal to the internal administration of mercury, which may be given in the form of a mild chloride, or of the bichloride, or the old fashioned blue pill. Another point is the enforcement of sustaining treatment. If quinine is used in suppositories, it should be in the form of the bimuriate or bisulphate, or the sulphate mixed with tartaric acid, so as to insure its being dissolved. Anodynes may be needed to quiet spasm.

DR. JOHN B. DEEVER: As has already been said, each case has to be treated on its own merits. There is much to be accomplished both by tracheotomy and by intubation in case of true croup. My experience, however, has been that in many cases the introduction of an intubation-tube occludes the larynx still further and increases the child's suffering; in those cases I do tracheotomy. I think that these operations are better applicable to cases of croup proper, and I

am not in favor of doing them where there is much depression, as occurs in true diphtheria. I cannot agree that all cases of croup die an easy death even when the tube is employed. I have seen them strangle as much after intubation or tracheotomy as before. The operation usually does give relief, but the inflammatory process may extend further down and the symptoms of obstruction may be renewed. I believe strongly in the use of mercury in these cases in order to get its constitutional effect. I use calomel and push it as far as I can, it being difficult to salivate children. The bichloride acts quicker, but it is more apt to irritate the gastro-intestinal tract. I believe that there is a difference between croup and diphtheria. I do not believe that they are one and the same disease. The one is local and the other is constitutional. This subject is a very interesting one, but I do not see how we are to instill into the minds of any the cases which should be intubated and those in which tracheotomy should be done. This question must be judged by the experience of the operator.

DR. W. S. STEWART: The doctor did not make a distinction between the true membranous croup and what is known as spasmodic. The latter can be relieved by emetics and counter-irritants, but in true membranous croup we need something more than emetics. I agree in regard to the use of the remedies to which reference has been made. I believe in calomel, or mercury, in other forms. I have been to many operations for tracheotomy, and have seen some cases when the operation was performed where I believe I should have still hoped for recovery without an operation. It is hardly fair to record such cases of recovery as a result of the tracheotomy. On one occasion I went three times to one case to assist in performing tracheotomy, and every time we were refused the privilege. Death was confidently prophesied by the attending physician, but the child recovered.

On another occasion I was attending a child where I feared death was going to result, and I advised the family to call in consultation a gentleman who intubated. During the interval of sending for the doctor and his arrival, the child improved; still, I asked the doctor if it was a good case. He said he regarded it as a good case for intubation. I told him to put in the tube, and turned the case over to him. On the second day the child was dead. I do not say that we should never operate or never use a tube, but I do say that those who are enthusiastic in regard to operation are often careless in their zeal to press the proper treatment. They do not pursue the medical treatment as perseveringly as they should.

Muriate of ammonia by itself is very hard on the stomachs of children, but a good combination is chloride of ammonium with chlorate of potassium and syrup of senega. I often combine with this, syrup of squills, ipecac and tolu; I also administer quinine by the mouth in the form of the tannate. This method often has a very good effect in arresting the development of ordinary membranous croup, when given in large and frequent doses, and the expectorant has the effect of absorbing the membrane already formed.

DR. G. BETTON MASSEY: There is a therapeutic item to which I have often wanted to direct the attention of general practitioners. During the ten years that I spent in general practice, I invariably prescribed insufflation of powdered sulphite of sodium in those cases of diphtheritic sore throat with general systemic disturbance that seemed to be the first stage of diphtheria. In all these cases the mem-

brane disappeared in from twelve to twenty-four hours, and it was a curious fact that in these ten years I did not see a bad case of diphtheria. Whether these membranous sore throats were of that nature, and were arrested, I am of course uncertain. The powder was insufflated through a paper roll every half-hour, the paper being burnt after each insufflation to prevent the wrong end being subsequently used and infecting the nurse.

DR. DANIEL LONGAKER: The theory which best fits the facts in these cases is that most of these cases are diphtheria, and that we have either a primary laryngeal diphtheria or a secondary laryngeal diphtheria. It often happens that a child is taken with membranous laryngitis, and two or three days later the membrane will appear in the fauces. Diphtheria is primarily a local disease, with, later, general manifestations. It seems to me that the local disease in the fauces is the point of invasion, and a poison is developed and absorbed with such serious effects. I do not think that any one method of treatment of croup can be maintained. Every case must be treated on its own merits. I have found the peroxide of hydrogen very efficient when used as a swab or as an atomized solution. I have used it in a number of cases in the past three or four months with satisfactory results. I do not advocate exclusive medicinal treatment or exclusive treatment by intubation, or exclusive treatment by tracheotomy. Each method has its own field of application.

DR. ROSENTHAL: I have used the peroxide of hydrogen for over a year. Of the kinds obtained in the markets—manufactured by Charles Marchand, Rosengarten & Sons, and Merck—I find that of Merck the best. At first I used it diluted, but gradually increased my strength of solution until now I use it absolutely pure. I apply it in membranous laryngitis, in the form of a spray, by means of an atomizer, quite copiously; and where the membranes are visible, the applications are made direct with probangs of cotton; my applications are made hourly. My remedial treatment is essentially antiseptic, mercury being used fearlessly. I also use stimulation freely; as, for instance, in a child of four years I gave as much as a gill of brandy during twenty four hours. I firmly believe that my success in the treatment of diphtheria, whether it be of the larynx or fauces or nose, is based on this antiseptic treatment; and in peroxide of hydrogen I think we have a most potent means of applying it. I attribute my success to it, for I believe, while diphtheria is a constitutional disease, the presence of the membrane hastens the absorption of poisons, and produces septicæmia and toxæmia; and in the peroxide of hydrogen we have a cleansing agent which quickly modifies, removes, or alters these conditions of things. In the last epidemic I have treated all forms except of the larynx, with but one death, and that one was in a rachitic child. There is one point that I wish to place myself on record as against, and that is the indiscriminate use of emetics in membranous laryngitis. I believe it is wrong in theory, wrong in practice; death is hastened by their use, and I have yet to see one case benefited or cured by their use. I believe that diphtheria and croup are clinically the same, whether the disease begins primarily in the larynx and extends upward, or in the pharynx and progresses downward. The youngest case intubated by me was four months and twenty-seven days; the oldest five years and six months. In all my cases peroxide of hydrogen was freely used.

DR. DACOSTA: I understood that the discussion was on croup, and not on diphtheria. The mode of onset, the symptoms, and the results of the two diseases are entirely different. Take a few points of the differential diagnosis:

In croup the attack is more sudden, and the patient recovers more rapidly. In diphtheria the patient does not recover fully for weeks, and the attack is apt to be followed by paralysis, which we do not find in croup.

Diphtheria is contagious; croup is not. Croup is found in isolated cases; diphtheria attacks whole families.

But if we are going to talk about diphtheria, I would indorse peroxide of hydrogen. I know nothing that will clear off the membrane quicker than it will.

DR. DEFOREST WILLARD: While there are such wide differences of opinion in regard to the pathology of these diseases, it is not strange that there should be these marked differences as to methods of treatment. Some of the speakers, perhaps, refer to one disease, while others refer to another. We all recognize that mild cases get well without much treatment, but there is another grade of cases which will die, whether treated medicinally or by intubation, or by tracheotomy. Reliable inferences cannot be drawn from a small number of cases, and even in larger numbers we all know that we may have a hundred successive cases of recovery in a certain disease, while all of the next ten may die. This is especially true in membranous croup and diphtheria. I am confident that I have saved a good many lives by tracheotomy, but I have also lost many. Yet the comfort secured to the patient has amply repaid me, even though death has subsequently taken place.

DR. TURNER: I was led to write this paper from the fact that I knew that certain cases of spasmodic laryngitis were intubated and reported as cases of recovery from croup. The treatment which I have mentioned will decide the question whether the case is one of spasmodic croup or not. I also employ calomel, and use quinine in the form of the bisulphate, in suppositories. It takes the membrane three or four days to be separated. It cannot always be removed by an emetic, but if you get rid of the spasm you give a great deal of relief. Asafetida has not been used before in croup. I do not say that intubation and tracheotomy are of no use, but where the membrane is below the trachea and in the bronchial tubes, the case cannot be relieved by these measures. The treatment which I advocate gives to the child sleep, rest and nourishment. Take a healthy child and treat it with emetics and the other things which have been mentioned, rousing it up every hour to spray its throat, and it would take a good constitution to stand that. Croup is not a very common disease. And in my paper I have referred not to diphtheritic croup, but to membranous croup.

In regard to the employment of calomel, I will state that I employ a purgative dose in the beginning of treatment, if constipation exists, to arouse secretions, and do not use it for its supposed action to dissolve the membrane.

The International Medical Magazine, Lippincott's new monthly, edited by Judson Daland, has made its appearance. It is gotten up in Lippincott's style, which means the best possible. It is well edited, its pages well filled with valuable papers from writers of high standing; in fact, a very worthy representative of the publishing-house medical periodical.

A CASE OF MALIGNANT DISEASE OF THE STOMACH IN WHICH GASTRO-ENTEROSTOMY WAS CONSIDERED.¹

By JOHN B. ROBERTS, M.D.

I DESIRE to briefly report the result of a case in which I was only deterred from making preparation for gastro-enterostomy by the debilitated condition of the patient, but in which the post-mortem findings showed the inutility of such an operation. The delay which prevented me from subjecting the patient to the expense and anxiety of so serious an abdominal operation is so justified by the pathological conditions that it has caused me to present the specimen for examination.

Upon being summoned to another State for surgical consultation, I found a man about fifty-two years of age suffering from great pain in the epigastrium. He was vomiting large amounts of fluid. The temperature was normal, but the muscular weakness was great, and sleeplessness pronounced. The abdomen was distended with gas, and there was a marked prominence in the neighborhood of the left hypogastrium. The patient had suffered for about four years with dyspeptic symptoms, during which time he had been under the care of many physicians. He had recently been treated by lavage, which relieved the pain temporarily, and he had suffered with such obstinate constipation as made the attending physician think that there was some obstruction in the alimentary tract. It was this as well as the excessive pain that induced him to call in surgical aid.

The character of the vomiting, the situation of the prominence in the left hypogastrium, and the general aspect of the case made it very evident to me that it was one of dilatation of the stomach. I gave an opinion that it was very possible that there was malignant disease in the neighborhood of the pylorus; but it was impossible to determine the question because of the distended abdomen, and the diagnosis was hence left undecided. The administration of food by the mouth was stopped entirely, and enemata of peptonized milk combined with whiskey were given every two hours, night and day. Lavage was continued to empty the stomach and relieve pain. This line of treatment was continued for about three weeks. The patient's discomfort was relieved, the pain disappeared, the vomiting discontinued, and the consequent reduction of tympany rendered it possible to detect a hard mass below the liver in the median line. The bowels in the meantime had become regular by the occasional administration of cascara. This for two weeks, however, was not needed, because of spontaneous evacuation of the bowels, probably due to the enemata. Microscopic examination of the vomited matter showed me that blood was present in the ejecta, and I now made a diagnosis of malignant disease.

At the end of three weeks small amounts of nourishment were given by the stomach. We commenced with a drachm of peptonized milk with a few drops of whiskey every two hours, and daily diminished the amount of food administered by the rectum. Gradually the amount of food taken into the stomach was increased until it reached three ounces every two hours. The prolonged rest during the period above mentioned seemed to have been beneficial to the stomach, so that the small amounts of food given at frequent intervals were digested without pain; there

¹ Philadelphia County Medical Society, February 10, 1892. Dr. L. K. Baldwin in the chair.

was no vomiting, though the tympany became more or less prominent.

At the time he began to take food by the mouth I told the patient that he had malignant disease of the stomach, and that exploratory examination was proper with a view of determining whether an artificial opening could be made between the stomach and intestine, or the growth removed. This was deferred until the strength of the patient should be somewhat improved under gastric alimentation. The patient, however, continued to lose ground, and died about a month after my first visit. When the food given by the stomach reached three and a half ounces he began to have pain.

The autopsy showed, as the specimen makes clear, malignant disease infiltrating about one-fourth of the long diameter of the stomach, with several nodular masses at the pylorus. The pylorus, however, is sufficiently patulous to admit readily the introduction of a finger-tip. There was, therefore, no marked obstruction. The cardia is much thinned, while the middle portion of the stomach presents the normal thickness and characteristics. An adhesion has taken place between the stomach and the liver at the point where the growth is most marked.

Gastric dilatation had occurred secondarily to malignant disease of the pylorus. The only time at which it seems to me gastro-enterostomy would have been wise was previous to his coming under the care of Dr. H. A. Stout, who called upon me for assistance; and it is very doubtful if at any time the operation would have been beneficial. The pylorus, as shown at the autopsy, must have had an opening as large as would probably have been made had the operation in question been performed; and the infiltration of the wall of the stomach for one-third of its length would have made the area for an opening between the stomach and intestine limited. An opening would have had to be made between the thinned and dilated portion of the stomach at the cardiac extremity and the large area infiltrated with malignant growth toward the pyloric end. This, of course, could have been done, but prolongation of life would probably not have been gained.

The facts that the man was walking about and attending to business and that the tumor presented no external manifestations make it extremely probable that an operation would not have been suggested previously to the time he came under the care of the physician who consulted me, except by an enthusiast.

I present the case partly because of the interesting character of the specimen, and partly as a contribution to a branch of abdominal surgery which is assuming increased importance.

The recent series of cases reported by Dr. N. Senn have been read by me with great interest; but the conclusion has almost been forced upon me that many of them were cases that scarcely justified operative procedure. Perhaps I am too conservative; but may it not be that he is too enthusiastic?

ACCIDENTAL CATARACT OPERATIONS.

By ERNEST B. SANGREE, A.M., M.D.,
Demonstrator of Histology in the Medico-Chirurgical College and Philadelphia Dental College.

PERHAPS the most remarkable instance of unpremeditated but successful ophthalmic surgery, was a case, the result of which was seen at Will's Eye Hospital some years since. An old man with a well-formed cataract in one eye was attacked by a

bull. The animal's horn struck the blind eye, broke open the cornea, ruptured the capsule and squeezed out the lens. He might have finished the operation by applying a bandage, had not the arrival of some farm hands induced him to retire before completing the performance. Nevertheless the wound healed kindly, and with the assistance of proper glasses the old farmer commanded good vision. Such incidents are noteworthy from their extreme rarity. This winter my attention was called to two somewhat similar instances of benefit from accidental injury. One case was that of a man of sixty, who had been completely blind in the right eye for three years before the accident. During an attack of la grippe early this winter, a violent fit of coughing resulted in dislocating upward the cataractous lens, allowing light to pass through about half the pupil. Suitable glasses enabled him to read with considerable satisfaction. The other eye was completely blind at the time I saw him.

The second case was that of a man of sixty-five, who had been quite blind in his left eye for one year, the right eye being fairly good. His accident was a blow on the upper rim of the left orbit from a falling brick. Although declaring that the eyeball itself had not also been struck, he was probably mistaken. At any rate he noticed, a few days afterwards, that a little vision was returning to his left eye. The improvement went on, the right eye at the same time growing rapidly cataractous, until at the time I saw him, two years after the accident, the right eye was entirely blind, whilst the left had moderately good vision; good enough at any rate to enable him to get about comfortably, though he could not see clearly enough to read. Ophthalmoscopic examination showed numerous striæ, doubtless shreds of the capsule, along with floating flocculi in the vitreous, which together obscured the light rays. I failed, however, to find the lens, and was inclined to think that it might have been broken up and absorbed, though it may possibly have escaped my search.

Society Notes.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON PEDIATRICS.

Meeting of February 11, 1892.

DR. WM. P. NORTHRUP, Chairman.

A CASE OF SPINA BIFIDA

WAS presented by DR. A. JACOBI. The patient was two months of age and the tumor which was present at birth was growing rapidly. The wall was becoming thin over the central portion, and without operation would soon burst and the child die. There was also talipes valgus and the sutures and fontanelles were very large.

A demonstration was given by Dr. M. Putnam-Jacobi to prove the fact that when the lung is collapsed percussion yields tympanitic resonance, but when extremely inflated, exaggerated pulmonary resonance.

DISCUSSION ON DIPHTHERIA.

DR. JOSEPH E. WINTERS read a paper entitled the BEST APPARATUS AND BEST DISINFECTANT FOR USE IN MOUTH AND NOSE.

The author assumed that the disease is caused by the Klebs-Loeffler bacillus; that it is primarily a local disease, the microbe elaborating in the throat

exudate a poison which is absorbed and carried into the circulation, the germ itself not being found in the blood or tissue. A point of vast importance in treatment is the fact that the specific germ on a perfectly healthy membrane does not provoke diphtheria. The primary indication, then, is not only to cleanse and disinfect the parts but to destroy the germs *in situ*.

The activity of the Klebs-Loeffler bacillus is impaired by even weak solutions of carbolic or boracic acids. The practical deduction from this is that at the outset we should attack the exudate or culture soil in order to prevent the microbic products from producing constitutional results. It is never safe, however, to employ means that will irritate the surrounding parts, for fresh points of infection are thus made. The only means of successfully disinfecting the throat and preventing sepsis is by irrigation.

For this purpose the child should be placed on the side of the crib and a rubber sheet arranged to catch the drippings, but he should, under no circumstances, be lifted from the horizontal position. If a Davidson syringe be used the cleansing will be more complete, and will meet with less resistance than with any other apparatus. The irrigating should be done through the nostrils, for they cannot be tightly closed like the mouth, and with the first flow of fluid from the nose into the throat the mouth is opened and everything is discharged through the nostrils and mouth.

It is occasionally necessary to syringe through the mouth. In this case the tip should be removed and the tube passed along the inner side of the cheek behind the last molar to the pharynx. In ordinary cases irrigation every two hours is sufficient; in severe cases it must be practised every hour, day and night.

For this irrigation nothing has proved as satisfactory as a ten per cent. solution of peroxide of hydrogen or a saturated solution of boracic acid. The passages must be thoroughly cleansed at each washing and one-half to one pint of solution will be required.

In the local treatment of diphtheria is included medicated steam from a croup kettle, and the inhalation of sulphurous acid gas through the burning of sulphur candles. For medicating the water in the croup kettle, add to one pint of water one ounce of spirits of turpentine and two drachms of oil of eucalyptus. In the use of the kettle plenty of rubber tubing is necessary, and a gas stove is the best means of generating the heat.

DR. H. D. CHAPIN read a paper on

QUARANTINE AND DISINFECTION IN LIMITED APARTMENTS.

The management of diphtheria in tenement houses formed the chief subject of consideration. The furniture should be removed as far as possible and the child placed on a cheap cot instead of a bed or sofa. The mother, if she must also attend the rest of the family, should wear a wrapper which can be removed on leaving the room. The area of contagion, when ventilation is good, is small, probably but a few feet. If the germs can all be destroyed *in situ* there will be no contagion. Old cloth or pieces of cheese cloth should be used about the patient and burned as soon as soiled. All articles of bedding should be shaken on the roof and exposed for a considerable time to sunlight and air, the two most powerful antiseptics at our command. The walls should be washed down with a sublimate solution, 1 to 1,000, and the same should be used in sinks and closets. Papered walls

may be cleansed with stale bread crumbs. The burning of sulphur, while it may not be of great efficacy, is undoubtedly of some value. It leads to thorough subsequent ventilation, at least. The throat and nasal passages of the other children of the family should be frequently sprayed with mild antiseptic solutions.

DR. L. EMMETT HOLT read a paper upon

FEEDING IN DIPHTHERIA; METHODS OF FORCED FEEDING.

In a disease like diphtheria, where the principal cause of death is asthenia or exhaustion, no question can exceed in importance that of nutrition and stimulation. The most common error in this direction is over-feeding and over-stimulation during the first few days. It too often happens that when the critical period arrives the over-burdened stomach refuses to do its work. The subject may be considered under three heads:

1. Character of food and stimulants.
2. Frequency of administration.
3. Forced feeding.

As to character of food little need be said except to condemn two articles frequently allowed, ice-cream and jellies, which interfere with taking more valuable food. The main reliance must be upon milk diluted according to the age of the child. Next to milk, beef broth, mutton broth, expressed beef juice, soft boiled eggs, milk toast, wine whey, oat meal or barley gruel. Junket, with a little wine added, and kumyss, when the child will take it, are valuable additions to the list.

In regard to the stimulants, brandy is best; but we must be guided by the child's whims, and give what he will take best.

Experiments with stomach washing show that the stomach is rarely empty sooner than two hours after a meal. It is a safe rule never to give food requiring digestion oftener than this. Stimulants and pre-digested food may be allowed at shorter intervals. The quantity of food given should be somewhat less than the child would take in health. It is best not to begin stimulants until they are indicated by the pulse or prostration; but they should then be pushed until the desired effect is produced, the only limit, in many cases, being the tolerance of the stomach. Unlike food they should be given in frequently repeated doses. A careful record of the exact amount of food taken and retained should always be kept that we may know where we stand.

It sometimes happens that the child absolutely refuses all nourishment and stimulants. Coaxing, threats, and commands are alike futile. Efforts to compel the child to take milk in teaspoonful doses results in the wasting of an immense amount of strength, while little or nothing is accomplished. It is at this juncture that the question of forced feeding arises. Rectal feeding in young children, owing to irritability of the sphincter, is almost impossible. Much more efficacious, and with far less disturbance to the patient, is forced feeding by the mouth or nose. The difficulties are surprisingly small. The ordinary apparatus for stomach washing is all that is required, the method of procedure being the same as in that process. Unless there is much resistance the mouth is to be chosen. Completely peptonized milk is to be preferred. The operation should be repeated once in four hours. In this way a proper amount of nutriment can be introduced with far less worry and resistance than by the spoon method.

The operation was demonstrated upon a child of ten months, a sufficient amount of milk being introduced in about ten seconds.

DR. J. A. JACOBI spoke upon the subject of

CONSTITUTIONAL TREATMENT IN DIPHTHERIA.

He has been convinced of the value of bichloride of mercury in all forms of the disease, especially the laryngeal. He gives it in large doses; a child of six months will take a quarter of a grain a day with no untoward symptoms. Diarrhoea is rare, and is quickly checked by a few drops of paregoric. Stimulants should not be delayed until signs of heart failure appear, for when that condition has once developed the patient is almost certainly lost. Very large doses are sometimes required, and they should be increased until an effect is produced. The doses of digitalis, camphor, and alcohol, as stated in the textbooks, are no guide whatever. If rejected by the stomach, they should be given hyperdermically. One part of camphor dissolved in 4 parts of sweet almond oil may be given hyperdermically with but slight local disturbance.

DR. AUGUST SEIBERT demonstrated his method of

SUBMENDRANOUS ANTISEPTIC INJECTIONS.

If the Klebs-Loeffler bacillus generates a poison within and underneath the pseudo-membrane, that is the place to attack it. He has therefore devised an implement consisting of a number of hyperdermic points set closely together on a small disc, by which an antiseptic may be injected beneath the membrane. As an antiseptic, he employs very strong chlorine water. The method has now been in use eighteen months with strikingly surprising results. It is designed to supplement, not to displace other local treatment, the injections being made but once a day, one or two, as a rule, being sufficient.

DR. BEVERLY ROBINSON inquired if fluid introduced into one nostril did not usually pass out by the other.

DR. WINTERS replied that in young children a portion passes by the mouth.

DR. VINBERG approved of sulphurous acid gas, as it gives marked relief to the patient.

DR. J. LEWIS SMITH said that he used a stronger solution of peroxide of hydrogen than that proposed by Dr. Winters. Stronger solutions can be used in the throat than in the nose.

DR. STOWELL said that the strength of the solution must be graded to suit the case. Peroxide of hydrogen, if too strong, will cause irritation.

DR. HOLT said that in a personal trial he had found a ten per cent. solution too strong for comfort.

DR. C. W. ALLEN described a screen of plain glass which he had seen used in Germany. It is held before the face of the patient during the examination of the throat. It does not obstruct the view and is an admirable protection to the physician if the patient coughs.

The Chairman urged that inasmuch as we know the specific germ which causes diphtheria and its habitat, that we definitely consider what remedies are for its destruction and what are for the simple comfort of the patient; that the physician spends his time destroying the germs which are thrown off directly from the patient's mouth and less to blaming sewer-gas and germs constantly floating in the air.

DR. FISCHER had made a series of examinations in tenement houses and had found the specific bacillus in the air in a number of instances. In one house

four cases developed on different floors along the same line of pipes.

DR. FLOYD M. CRANDALL,

Secretary.

CLINICAL SOCIETY OF MARYLAND.

THE two hundred and sixty-second regular meeting of the Society was called to order by President ROBERT W. JOHNSON.

DR. HIRAM WOODS read a paper on

THE TREATMENT OF GRANULAR CONJUNCTIVITIS,

and exhibited patients treated by the method he now uses, viz., that of Dr. Knapp, which is the squeezing out of the spawn-like lymph follicles by means of forceps specially adapted to the purpose.

CASE I.—A man with pannus of three months' duration; had been treated all this time with blue stone with no improvement. Forceps were used very gently; some granulations pressed out. Considerable pain and much bleeding from conjunctiva ensued. Following day man's eyes were wide open and photophobia completely relieved. Squeezed out some more granulations. He came back next day with conjunctiva quite clear. Has not returned since.

CASE II.—Girl with so-called diffused trachoma of two years' duration. Was treated all last summer with blue stone. In November was suffering intensely; the entire upper lid of right eye covered with spawn-like, soft, follicular granulations, extending over onto the ocular conjunctiva. Two operations performed. At the first nearly all the granulations of palpebral conjunctiva were squeezed out; at the second all those that had escaped the first operation were destroyed. There was swelling and pain for a couple of days; then these symptoms disappeared, and photophobia also. There was still a few granulations in the retrotarsal fold, which will be removed. The palpebral surface is quite smooth.

CASE III.—Follicular trachoma of long duration. Granulations of connective tissue variety buried deep in conjunctiva; dense, heavy pannus along upper part of cornea, and whole cornea vascular. Follicles pressed out with exercise of considerable force. Conjunctiva became perfectly smooth. After a month, inflammation was set up by small amount of jequirity, with the view of clearing up the pannus. The pannus cleared up, the photophobia has entirely disappeared, and the eye is almost well.

CASE IV.—Man troubled with trachoma for four years. Came to hospital early in January, and was operated on without previous treatment. Granulations were of connective tissue kind. A great deal of thick, heavy pannus; photophobia considerable, lachrymation much, and whole eye congested. Granulations squeezed out by using considerable force. There was a good deal of pain and considerable reaction, and after two weeks the eye was watery and somewhat painful. There is now no watering, the eye is clearing up, the lid is smooth, and he is in a fair way to get well of his pannus.

Two other cases, both in young Jewish women, were in the atrophic stage, and very little could be done except to relieve irritation. Symptoms: both suffering intensely from photophobia and lachrymation. One operated on a week ago, and is almost entirely relieved of photophobia. The other, operated on yesterday, feels better to-day than before the operation. Two cases operated upon at the hospital never returned.

His experience with these cases, together with the experience of Dr. Knapp in his one hundred and

fourteen published cases, leads Dr. Woods to the conclusion that this is the best method ever devised for the relief of granular conjunctivitis.

DR. J. E. MICHAEL: I was for a number of years Dr. Chisolm's first assistant at the Presbyterian Eye and Ear Hospital, and I remember very vividly the many cases of trachoma that came to us day after day, and month after month, and year after year, to have nitrate of silver or blue stone applied, and it was our habit to regard these cases as almost hopeless. I have noticed, of course, a gradual improvement in some of them, which would go to a certain point and then stop. I have never seen any cases which have shown anything like the improvement seen in these cases exhibited by Dr. Woods. I want to express my satisfaction that so important an advance has been made in treating such an obstinate and troublesome pathological condition.

DR. WILMER BRINTON read a paper on

PHLEGMASIA ALBA DOLENS, WITH REPORT OF THREE CASES.

In about eleven hundred cases of obstetrics, Dr. Brinton has seen three cases of phlegmasia alba dolens, or the so-called "milk-leg." The various views as to its causation were given. It is now generally held that it is caused by phlebitis, that phlebitis being an extension of the disease from the vessels of the uterus. Virchow claims it to be due to a physiological thrombosis.

CASE I.—Mrs. D., confined in November, 1884; second child; labor rapid; lying-in period uneventful until eleventh day; temperature and pulse normal for seven days; the record no longer kept. On eleventh day patient was found in bed crying with pain in left leg; pulse, 120; temperature, $101\frac{1}{2}$; had had a chill in the morning, followed by feeling of malaise and intense pain in left leg; leg was swollen and hot to touch; swelling much greater next day; pulse and temperature became normal in a few days; swelling gradually disappeared, first from foot, then from the calf, and then from the fleshy part of leg. It was three months before she ceased to complain of stiffness and soreness.

CASE II.—Mrs. S., confined by a widwife, October 8, 1888. No trouble or complications. Remained in bed till tenth day, and then resumed her domestic duties. On the night of fourteenth day after confinement had a chill, followed by pain through body and intense headache. Next morning was somewhat better, but could not move left leg without pain, and it was rapidly swelling. Dr. Brinton was called in next day and found patient in bed; pulse, 120; temperature, $101\frac{1}{2}$; complained of a general feeling of malaise, severe headache, and very severe pains in left leg. Leg much swollen and oedematous, especially in calf and about the ankle; especially tender to touch on inner side of popliteal space. In two days swelling about ankle began to disappear. In seventeen days got out of bed and soon began to move about and attend to household duties.

CASE III.—Mrs. T., delivered September 1, 1891, of twins. It was a case of placenta prævia centralis, with much loss of blood, from which the patient rapidly recovered. Lying-in period uneventful, although pulse and temperature slightly above normal; pulse, 85 to 100; and temperature, $99\frac{1}{2}$ to 101. On tenth day set up for a short time. On evening of eleventh day temperature rose to 104, and pulse to 126. Had had decided rigor about midday. Next morning pulse 100, temperature, 101. Examination revealed a case of septic endometritis, due, doubtless, to lacerated

cervix. The "skilled" nurse had given the injections in such an imperfect manner that no benefit had been derived. On the fourth day from the beginning of the attack the left leg showed marked signs of phlebitis. Pain first felt below Poupart's ligament, and extending down the thigh to the leg. The leg became greatly swollen. In ten days painful symptoms subsided and patient moved the limb without much pain, when suddenly pulse became rapid, temperature 104, and right leg became involved more extensively than the left. About seven weeks from time of delivery she was able to be removed to Washington. She is now enjoying the best of health.

The treatment of these cases was by internal administration of quinine, opium, aconite and phenacetine, and locally, absolute rest of limb, application of flaxseed poultices to certain parts of limb for a few days, and later the limb was rubbed from time to time with camphorated oil, and a flannel bandage applied daily from toes upward. In Case III the uterus was washed out daily for some time with bichloride solution.

DR. W. S. GARDNER: I would like to ask Dr. Brinton if he kept the temperature record of that first case up to the time she was attacked.

DR. BRINTON: I did not. It is now several years since, but I am satisfied that the pulse and temperature were practically normal; if not I would have made a record of the case.

DR. GARDNER: There is quite a difference between a "practically" normal temperature and an actually normal temperature. I believe that if the temperature records of all these cases are kept accurately you will find that few, if any, will have a normal temperature from the time of confinement till the time that phlegmasia alba dolens comes on. I think it is a fact that is about as well established as anything connected with septic troubles of the puerperal state that this is one of the conditions that we have as the result of septic infection, that it is nothing more than a connective tissue inflammation in the leg due to sepsis. The clot in the veins is entirely a secondary affair, and has nothing materially to do with the condition. There are many post-mortems reported in which there were no clot and no phlebitis. Even if this were not the case the retarding of the return flow of blood would not give the condition found in phlegmasia alba dolens. Retarding would give you a simple cedema; in phlegmasia you have, in addition to cedema, what seems to be more of an inflammatory condition, although it is not associated with the redness of ordinary inflammation. It is an infiltration into the tissues instead of a pouring out of serous fluid into spaces beneath the skin, so that the limb becomes practically solid, and does not pit readily on pressure.

So far as the treatment of these cases is concerned, it is just the treatment of all our infectious diseases, except syphilis and malarial fever. You cannot do anything with them; they either get well or they die. You cannot cure typhoid fever, nor scarlet fever, nor phlegmasia alba dolens, nor troubles where there are micro-organisms developing in the tissues. You can only treat the symptoms as they arrive.

DR. J. E. MICHAEL: The question as to the necessarily septic nature of phlegmasia alba dolens is not by any means settled, and Dr. Gardner's statement that a careful record would, in all cases, show a rise of temperature or other conditions indicating a septic state of the patient is not carried out by the facts in many instances. I am convinced that Dr. Brinton's cases are as he stated them to be. He took the temperature for a certain number of days and finding no

rise did not take it again. I have seen one case of phlegmasia. The woman was dropsical, badly nourished and badly cared for. She had general oedema and oedema of the lungs and every evidence of advanced kidney disease. She was confined successfully. For several days her temperature was normal, that is under 100° , for we regard, in such cases, anything under a hundred as normal. On the twelfth day there was the sudden occurrence of pain and the other symptoms which Dr. Brinton has given as indicative of beginning of phlegmasia alba dolens, and the case turned out to be so, and had a fatal issue. The uterus, vagina and everything connected with the generative organs were absolutely free from any evidence of previously existing inflammation. There was a clot in the femoral iliac vein which had undergone softening and was described by the pathologist as the puriform softening of Virchow. I think there is a question if there was anything which comes under the description of puerperal septicæmia and its various manifestations. What adds to the interest of this discussion is the statement made by Dr. Brinton, which is in accordance with our histories and experience, that cases of phlegmasia alba dolens occur, as a rule, in patients having a normal puerperium. The condition of the blood, or whatever it may be which predisposes it to easy clotting is undoubtedly, according to the views of Virchow, responsible for its clotting under these circumstances. I am convinced that at least a portion of these cases are not associated with distinct phlebitis, but are the result of primary clot formation, and do not begin until the clot is formed.

The other side of the case, and one that is taken by a good many, including Dr. Gardner, is that phlegmasia alba dolens always indicates a septic condition. I am inclined to think that there is a septic condition which produces, clinically speaking, the same condition which we find in phlegmasia alba dolens. We have the occurrence of phlebitis in the neighborhood of the generative tract and in the adnexa, and we may have a phlebitis which would involve the femoral vein and would produce the clot and the general train of symptoms following. I do not think we have grounds for sepsis in all the cases. I believe the only satisfactory solution can be arrived at by gathering together all possible information about the occurrence of this disease in lying-in hospitals now, and comparing it with its occurrence in years gone by, when septic conditions prevailed to such an extent. Virchow says that in the examination of these clots, in cases that terminate fatally, we have an appearance of pus surrounding the vessel and which would, on careless examination, be taken for pus, but in which the most scrutinizing examination reveals no pus and no bacteria, so I am inclined to think that we can have phlegmasia alba dolens with no septic infection whatever. I am inclined to think that two of the cases spoken of by Dr. Brinton were of this kind.

Another point bearing on this subject in a most practical way is that in by far the greater majority of cases where we do have positive puerperal septicæmia, we do not have phlegmasia alba dolens.

DR. J. H. BRANHAM: As Dr. Michael has said, it is difficult to decide whether all cases of this disease have the same cause. Where there is a clot in the vein, if the trouble begins as an infection, the organisms enter some of the uterine vessels, and gradually extend to the larger vessels; this is the theory maintained by many good observers. If it is simply clotting of blood extending from the smaller veins into the larger ones, this can occur without sepsis. Some

cases are not accompanied by these clots at all; in these cases the swelling is due, I think, to stoppage of the lymph vessels.

The occurrence of chill, and the rise of temperature and pulse in these cases look as though there was some form of septic infection. I do not believe that simple stoppage of circulation, without some infection in addition, causes these symptoms. As to how the infection gets there there is some doubt. It is well-known that we may have a very late form of sepsis in obstetrical cases. Without any previous rise of temperature decided septic trouble may come on ten to eleven days after labor. Either there was a late infection, or there was at first a very slight infection, and then it took time for sufficient development of the organisms to produce decided septic symptoms.

DR. W. S. GARDNER: With reference to the history of these cases we know that it is an extremely rare disease. Tyler Smith gives us a history of one man having three successive cases of labor, in each of which phlegmasia alba dolens occurred. There was another series of three successive cases in this town a few years ago. While these series of cases are very short, and might be considered as coincidences in any ordinary disease, yet considering the extreme rarity of phlegmasia alba dolens, I think a series of even three cases is strong presumptive evidence that it must be due to something which can be communicated by some one to the patients.

If the remarkable degree of disorganization which is found in these cases is not due to micro-organisms, how then are you going to account for it?

DR. BRINTON: I am inclined to think that sepsis is the cause in a certain number, but not in all cases.

As to normal temperature, in the vast majority of cases, I think, that the temperature will be 98° – 99° , and that in many cases there is a normal temperature of 100.5° . In some cases where the temperature has been 100° the lying-in period has been as uneventful as where the temperature was 98.5° .

W. F. WATSON, M.D., *Secretary.*

1603 N. BROADWAY, BALTIMORE, MD.

TREATMENT OF NEURASTHENIA BY TRANSFUSION OF NERVINE MATTER.—M. Constantin Paul related at the last meeting of the Académie de Médecine, the cases of a certain number of patients whom he treated by subcutaneous injections of the nervine solution according to the method of Brown-Séquard, into the cellular tissue. The patients were classed thus: Three chlorotic neurasthenics, three classical neurasthenics and four tabetics. The liquid which M. Paul used was a solution (1-10) of the grey matter of the brain of a sheep, and properly sterilized. The liquid was injected into the cellular tissue in the groin or loins at a dose equaling five times a Pravaz syringe. It was well tolerated, and provoked no reaction, local or general. Out of more than two hundred injections practised on the ten patients, no case of abscess was once observed. The first effect experienced by the patient was that of revived strength and a *bien être*, muscular impotence diminished rapidly, the pains down the vertebral column and the spinal irritation disappeared after the first few injections, as well as the lancinating pains in the patients suffering from locomotor ataxy. The patients recovered their appetite and their weight increased rapidly. Where the sexual powers were weakened an improvement took place also. In conclusion, M. Paul said that his method cured more effectually and more rapidly patients of the above class than all the treatment heretofore recommended, such as iron, arsenic, phosphates, opium, hydrotherapy, electricity, etc.

The Times and Register

A Weekly Journal of Medicine and Surgery.

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THE LEPER AS A HOTEL COOK.

OUR readers have learned from the dailies that a Japanese leper was discovered at the Peabody Hotel in Philadelphia, where he was acting as pastry cook. More than that, he was leprosy to an advanced degree, so much so that he is said to have been unable to stand while at his work. It is uncertain as yet whether his employer, Dr. Paine, was aware of the nature of his disease; yet, as the man came to the doctor for treatment, and was giving his services in return for his treatment, it seems most probable that the true nature of the case must have been known to Dr. Paine.

Leprosy exists in North America under a number of diverse circumstances. The Louisiana Creoles have had a leper colony for over a century. Another exists in Nova Scotia; while the Norwegian immigrants established the disease in Minnesota. In each of these, however, the disease appears to be steadily decreasing; although in Nova Scotia cases that have not been isolated have communicated the disease to others not connected by blood with any leprosy family. But, in addition to these three foci, there is the graver danger from Chinese immigration. All over the land there has been a silent but steady infiltration of Chinese. These remain as aliens; they never assimilate; they retain their own customs, religion, and habits; and but little is really known of them by our own people. Wherever they have settled they have brought with them their peculiar vices and diseases. The Chinese quarter of a city is a moral lazaretto. Among the inferior races leprosy has spread from the Chinese with frightful effect; the Hawaiians, in particular, being threatened with extinction by it. It is unnecessary to attribute this to any special susceptibility to this disease on the part of the lower races of man; the closer physical association with the Chinese, and the ignorance of hygienic observances being amply sufficient to explain the occurrence.

But the white race has been fully proved to be liable to this disease when the exposure has been prolonged. Twenty years ago it was said to the writer in South Africa that leprosy was unknown among the

Europeans; but since then the Robbens Island Lazaretto has received a due proportion of white patients. Every priest who has located in Molokai has, in time, become leprosy. Our readers may recollect that the leper who was discovered cooking in a Philadelphia restaurant a few years ago, was an American woman who had resided among lepers in South America. Everywhere it has been found that unrestrained intercourse between lepers and the community in which they live has been followed by the gradual extension of the disease, and that segregation of the lepers has resulted in its gradual extinction. Thus we are again forced to occupy, from the standpoint of medical science, a position in relation to leprosy analogous to that held under the Mosaic dispensation. There is little doubt that the observance of the segregation so severely inculcated by the ancient Jewish law-givers would, in time, cause the complete extinction of leprosy. The discovery of the bacillus lepræ, by Hansen, and its habitat in the nerve trunks, beneath the surface of the body, explains at once the contagiousness of the disease, and the fact that contagion only occurs after prolonged and intimate contact with the leper, which has multiplied the opportunities for a transference of the bacilli which can only be possible on rare occasions. A husband may sleep with a leprosy wife for years without once a chance being afforded for a transferral of the bacilli from one to the other; but there is almost a certainty that, sooner or later, such a migration will occur, either directly from person to person, or through the medium of infected objects.

Public sentiment is unanimous in the support of the Board of Health, in removing the leper to the hospital, disinfecting the hotel in the most radical manner, and prosecuting the proprietor for maintaining a nuisance. There is one dissenting voice, however: A New York medical journal, that failed to see anything reprehensible in the admission into that port of typhus fever, characterizes the action of our Board of Health an outbreak of "leprophobia." The editor probably prefers a little leprosy in his pie. We would suggest that Mr. Wing be discharged from custody and sent to New York; provided the erudite compiler of dictionaries agrees to receive the leper into his family and install him as pastry cook. The host should also notify his guests, when invited to partake of his hospitality, that they ran some chance of partaking of the bacillus lepræ with their comforts. We fear that solitude would reign in his "banquet hall deserted," and that he would find leprophobia not confined to Philadelphia.

TUBERCULIN IN VETERINARY PRACTICE.

TUBERCULOSIS, having been suspected in a large herd of Jersey cattle at Villanova, Prof. Pearson applied the tuberculin test to the suspected animals. The owners announced that on Wednesday, March 16, the cattle in which febrile reaction followed the inoculation would be slaughtered, and an examination made, with a view of determining how far the accuracy of this test can be trusted. Readers of this journal have been rendered familiar with this import-

ant work through the reports of Professors Dixon and Quill, who have shown that Koch's tuberculin produces the reaction in tuberculous animals, and also that a similar reaction follows the inoculation with kreatin and other members of the amide group. This method of detecting tuberculosis in animals has been adopted by the city of Philadelphia, and several suspected animals have been subjected to it. In one case a cow was pronounced in an advanced state of tubercular disease, but the injections caused no reaction. The animal was slaughtered and found to be free from tuberculosis, the symptoms being apparently due to starvation.

The present experiment will attract unusual attention, owing to the fact that the affected herd is one of the finest in the State. The owner, Mr. J. E. Gillingham, began to stock his farm with Jerseys in 1882, and has bred largely during the past ten years. The loss by destroying the affected cattle will reach \$5,000. Should Professor Dixon's reports be corroborated by this trial, it is probable that there will be a widespread demand for tuberculin for veterinarian's use. It is to be hoped that other owners of fine cattle will take the high moral stand assumed by Mr. Gillingham, and have every animal slaughtered that is pronounced tuberculous. It is generally understood that high-bred cattle, especially those from the Channel Islands, are peculiarly prone to tuberculosis, and this has inspired many with a well-founded dread of "Alderney" milk. Many physicians forbid the use of this milk in families under their direction, preferring the milk from native cattle. Were the herds to be regularly inspected by skilled veterinarians, and all suspected animals promptly tested by inoculation, a great danger, at least a great source of dread, would be removed from the consumers. The great importance of Dixon's experiments with kreatin is here seen, for as tuberculin is shrewdly suspected of having communicated tuberculosis, the advantage of having an agent in kreatin, that is free from this danger, is obvious.

OCULAR APPEARANCES.

OF all the external signs of internal disease or disorders that arrest the physician's attention, the condition of the eyes is probably the first to attract his notice. The state of the pulse, tongue, and temperature, and the general appearance of the patient are finger-posts that indicate special examination to further elucidate the case; but the eye and its pupil are also unerring guides to the observant practitioner; and start him at once on the road to a correct diagnosis, both by the significance of their appearance, and by enabling him to exclude many diseases in which they play no part.

The eyes are congested in scarlet fever, variola, rubeola, yellow fever, typhus fever and meningitis. They are projecting in asphyxia, hydrocephalus, hydrophobia, exophthalmic goitre, and sometimes in functional heart disease; and sunken in collapse, cholera, and hectic. They are staring in convulsions, apoplexy, catalepsy, meningitis and dementia. They are rolling in epilepsy and tuberculous menin-

gitis; and they are photophobic in hysteria, meningitis and cephalalgia.

The pupils are dilated in syncope, hysteria, collapse, asphyxia, epilepsy, drowning, uræmia, coma; generally in phthisis; and in poisoning by belladonna, atropia, fungi, and many vegetable irritants and narcotics. They are contracted in concussion, sunstroke, typhus fever, hemorrhage of the pons; and in poisoning by opium, morphine, prussic acid, calabar bean, ergot of rye, and pilocarpine. They are contracted at first and afterwards dilated in compression of the brain, and in poisoning by alcohol, ether and chloroform; and they are dilated at first and afterwards contracted in severe apoplexy. They are unequal in paralysis, compression of the brain, and posterior spinal sclerosis. And they are frequently oscillating in epilepsy, typhus and spinal sclerosis.

In diseases of the eyes the external signs also facilitate the diagnosis. They are congested in conjunctivitis, trachoma, and ophthalmia; dilated in mydriasis, glaucoma, and amaurosis; contracted in myosis, retinitis, and iritis; photophobic in strumous ophthalmia, amaurosis, iritis, scleritis, choroiditis, and retinitis; and often oscillating in amaurosis.

LOUIS LEWIS, M.D.

Annotation.

DR. WARE, Commissioner of Health of Chicago, and Dr. Lyman, Professor of Practice in Rush Medical College, are having a newspaper controversy over the reporting of contagious diseases. It is the custom in Chicago to placard houses containing contagious diseases, and this renders the service unpopular. Dr. Ware simply demands a compliance with the law, as it stands, while Dr. Lyman claims that a law that forces the physician to perform a service without compensation is unjust. An effort is being made to have an investigation of the matter. If this takes the form of a request for such legislation as will secure a just compensation to the physician for the service rendered, it is probable that this can be done. Unfortunately, it appears more likely that there will be simply a show of hostility against the health office for performing the official duty of enforcing the law, in which case public sentiment will scarcely be with the physicians.

Letters to the Editor.

CAN you give the formula of Olive Branch Pile Remedy? T. F. STOCKDILL, M. D.
RURAL VALLEY, PA.

["Olive Branch" consists of powdered jequirity, made into suppositories, with olive oil and cocoa butter.—ED.]

FRACTURE OF THE HYOID BONE.

ON Wednesday afternoon Mrs. C., aged twenty-five, called at my office and wished me to treat her throat, saying that it was sore. She could then speak only in a whisper. In my examination I found the pharynx swollen and congested, and as the tongue was depressed it caused severe pain and

suffocation. Externally over the hyoid was marked ecchymosis.

The appearance seemed to me very peculiar, different from any case that I had ever seen. I said to the lady, "you must tell me all about how this happened," and after a good deal of urging, she confessed that on Monday evening, this being Wednesday, when in a quarrel with her husband he had grabbed her by the throat and choked her twice, placing his thumbs over the hyoid bone. The first time he did not exert much force, then renewing his attack the same as before, he choked her until suddenly she experienced a very severe pain and fainted. She was put to bed, and during the night she suffered extremely from suffocation, deglutition being very difficult. On Tuesday she felt a little better, but could only take liquid food, and even that she thought would suffocate her. That night she was about the same, but grew worse on Wednesday, and then consulted me.

The swelling was so great that I could not determine the exact condition at that time, so prescribed Slevin's inhalation and poultices to the neck; this reduced the swelling so that on Thursday, by having an assistant hold the tongue out as far as possible, pressing my finger down the throat, compressing externally I could distinctly feel the fracture of the greater cornua, near the attachment of the hyoglossus; all the pain and tenderness being at this point. I asked for a consultation, which was granted; the consultant agreed with me in my diagnosis. Will report the result and treatment later.

A. L. SHERMAN, M.D.

325 NINTH STREET, BROOKLYN.

INFUSION OF TRITICUM COMP.

THIS term I would apply as a proper professional name to the advertised "Garfield Tea." This popular laxative and diuretic, composed of the simplest herbs, as a proprietary medicine makes these herbs altogether too expensive for poor people. I therefore suggest the term above and present the formula for it as follows:

R—Sennæ folii.
Tritici repens.....āā 25 parts.
Balmionia.....1 part.

M.—One to two heaping teaspoonfuls to a cup of water, steeped as common tea should be steeped, viz.: Put in tin dish and pour the water on absolutely boiling hot; stir and steep three minutes and no longer. This extracts the virtue and leaves the bad taste and gripping elements of the senna behind. Drink this as hot as possible on retiring at night. There is no gripping about it and the light stimulation of the kidneys is more agreeable than otherwise.

This taken in greater or less quantities every night for a time will work wonders for those who need the laxative. As for the diuretic qualities, they are as much needed as were the diuretic qualities of the waters of a certain spring near a girl's seminary. The seminary was advertised over the advantages the young ladies might receive from those diuretic waters, as though all girls needed them.

Any apothecary can prepare and keep on hand such mixtures of herbs, using better senna than that found in the proprietary Garfield tea. This makes a very convenient mixture for every family to keep on hand for family use, and offers a proper prescription for the physician.

E. CHENERY, M.D.

WANTED.—Reports on typhoid fever from every State and Territory in the Union. Give data as to prevalence, types, peculiarities, mortality and treatment.

The Medical Digest.

TURPENTINE IN PNEUMONIA.—For the past four years I have relied almost entirely in the treatment of pneumonia on the oil of turpentine, regardless of the stages of the disease, the pulse or temperature, giving it in adults in doses from 30 to 60 minims every two or three hours, either in capsules or in emulsion, the former preferred. This treatment, aided by constant *dry heat* to the lungs, front and back, with hot milk diet or beef essence (a receipt for which will be found in this number), has really seemed to me to have robbed the disease of all its horrors. When first told of this treatment by Dr. Juke Johnson, of Canada, to whom I will always feel indebted, I naturally feared strangury, but in one single case out of a great many have I seen a single symptom.—*Hot Springs Med. Jour.*

DR. C. D. LIPPINCOTT offers the following as a substitute for listerine:

R.—Acid benzoic..... 32 gr.
Sodium bichlorate..... 1 oz. 32 gr.
Boric acid..... 2 oz. 64 gr.
Dissolve with the aid of heat in distilled water..... 48 oz.
Thymol..... 160 gr.
Eucalyptol..... 24 drops.
Oil of peppermint..... 24 drops.
Oil of wintergreen..... 40 drops.
Oil of white thyme..... 8 drops.
Previously dissolved in alcohol (94 per cent.)..... 24 oz.
Mix the two solutions, add caramel, 10 drops.
Distilled water q. s. to make 1 gal.

Let the mixture stand twenty-four hours, and finally pass through a wetted double filter.

—Formulary.

ORIFICAL SURGERY.—In conclusion, let me sum up the entire subject in a single sentence. Bring me an individual with clean lips and nostrils; a palate of proper length and unobtruding tonsils; a rectum that presents neither piles, prolapsus, fissure, ulcer, pockets nor papillæ—an individual whose sexual orifices are smooth and free from all irritation; if it be a man, his foreskin shall be free, the frenum of sufficient length, the urethral passage smooth and normal in size, especially in its prostate portion; if a woman, her hymen must be pale and atrophied, her urethra devoid of caruncles and ulcerations, her internal and external ora uteri reasonably patulous, and without undue sensitiveness; bring such an individual, and I will point to the same person and show you a human being whose digestion is good, whose capillary circulation is superb, whose very existence is a constant source of uninterrupted delights. Such men and women maintain a steady, poise of mind and body—they live to the fullness of time, and, unless removed by accident, their dissolution takes place on the principle of the "one-hoss shay"—they settle slowly and peacefully into their last sleep, just because their life's time-piece has run down. On the other hand, introduce to me a mortal suffering with passive congestion in various parts, whose blood finds its lazy way back to the heart by slow stages because the peristaltic action of the arteries is tired out—a person whose vitality is low, and whose poor, enfeebled body begins to be the prey of inherited or acquired tendencies—consumption, scrofula, syphilis, organic derangements of whatever form they may take—show me such an individual, and they are as

numerous as withered leaves in autumn, and I will stake the reputation of this idea that I shall be able, without straining a point, to find legitimate fault with the condition of some one or more of the various orifices of the body.—*Columbus Med. Jour.*

AT THE HARVEIAN SOCIETY OF LONDON.—Mr. Howard Marsh read a paper on senile tuberculosis, a title which, in view of recent advances of pathology, he had ventured to substitute for that of senile scrofula originally used by Sir James Paget. He thought all cases occurring in patients over fifty should be regarded as senile. He related the case of a man, aged sixty-three, who had tuberculous disease of the knee, going on to suppuration, and who had somewhat advanced phthisis of both lungs. Amputation was performed, and rapid healing of the wound was followed by marked improvement of the general health. A tuberculous knee-joint was also shown from a lady, aged sixty-seven, in whom Mr. T. Smith had performed amputation, and who made a good recovery. Particulars of four cases of senile tuberculosis of the hip-joint were given, in two of which the patients had phthisis, while a third, a patient under the care of Mr. Langton, died of general tuberculosis attended with symptoms of tuberculous meningitis. Mr. Marsh described four cases of caries of the spine in the old (one of them having been under Mr. Butlin), two cases of tuberculosis of the wrist, and two of the testis. In the great majority of the cases related suppuration had occurred. Mr. Marsh discussed the diagnosis (which was often very obscure in the early stage) between senile tuberculosis and osteo-arthritis; and between the former and malignant disease. In cases in which the lymphatic glands were affected, senile tuberculosis showed a strong tendency to suppuration, and was often inveterate. In some cases, however, sound repair had occurred. Treatment must, as in younger subjects, aim at improvement of the general health; local rest must be secured, and matter must be evacuated aseptically as soon as it was detected. In many instances amputation became necessary, and in the majority of cases this was well borne, the wound healed favorably, and often very quickly.—*Brit. Med. Jour.*

ALCOHOLISM AND TUBERCULOSIS.—From the histories given by patients, and from the evidence afforded by *post-mortem* examinations, the conclusion has been forced upon me that tubercle is more common among the alcoholic than is generally believed. I have collected from the *post-mortem* records of St. Thomas' Hospital for the past thirteen years 75 fatal cases of tuberculosis in which there was a strong history of alcoholism; in only 10 of these was there any history of phthisis in the family; in 46, or in over sixty per cent., the liver was cirrhotic. These cases by no means include all the intemperate who died with tubercle. In a considerable additional number of other cases, of tuberculosis there was a strong suspicion of alcoholism. All doubtful cases, however, have been purposely omitted. In 4 cases tubercle affected the peritoneum alone, in 1 case the pleura alone, and in 3 cases the peritoneum and pleura alone. In the remaining 67 cases the lungs were affected; in 47 of the latter there were vomica; in many of these the vomica were small and multiple, it being rather the exception to find a case of considerable excavation. In 29 there was bronchopneumonic consolidation; in 12 there was increase of connective tissue; in 43 there was grey tubercle present; in 19 there was caseous tubercle, the two varieties being both present in 11 cases. There was

also tuberculosis ulceration of the intestines in 21, of the larynx in 13, tubercle of the pleura in 5, tubercle of the peritoneum in 12, of the meninges in 5, of the kidneys in 8, of the spleen in 4.

It may be concluded from these facts that the commoner type of alcoholic phthisis is a combination of excavation with broncho-pneumonic consolidation, and that there is usually a considerable deposit of grey tubercle present in the lung. The fibroid change is the rarer form, occurring in only 12 out of 67 cases. In a large proportion there was tubercle present in other organs. The peritoneum was affected in a total of 19 cases. Fifty-nine of the cases were males, 16 were females, a ratio of about 4 to 1.

As regards the ages of these patients, they were in 12 cases over 20 years of age and under 30, 25 cases over 30 and under 40, 25 cases over 40 and under 50, 7 cases between 50 and 60, and 5 between 60 and 70. In the remaining case the age was 73. The reason for the number of cases being greater in middle life than in early adult life is probably because alcoholism is more frequent at that period than at an earlier one, and also because the longer the habit is indulged in the more susceptible the patient becomes.

The duration of symptoms in the 29 cases uncomplicated with cirrhosis was doubtful in 13, six months or less in 13, sixteen months, eighteen months, and three years respectively in the remainder, giving an average duration much below the average.

My experience among out-patients at the Brompton Hospital is that a considerable proportion of the phthisical—especially of the men—have been alcoholic, and I should say that a history of alcoholism is a very common antecedent in those cases where there is no inherited susceptibility to tubercle. As regards women, it is impossible to say to what extent alcohol is responsible for the disease, it being very uncommon for a woman to own to alcoholic habits.

In alcoholic cases the condition of the patient is generally worse than would be expected from the amount of disease revealed by physical examination. It is therefore specially important in such cases, when there are any chest symptoms, to examine the sputum for bacilli. By this means I have been able to make an early diagnosis of phthisis when the examination of the chest was negative. In alcoholic cases I have found that the progress of the disease, as a rule, is rapid and the prognosis particularly unfavorable.

The belief that, as regards people of any age, alcoholic drinks in excess act as a preventive of tubercle, I consider not only not borne out by experience, but altogether contrary to it. Without *post-mortem* examinations conclusions as to the absence of tubercle are fallacious and of no practical value.

—Mackenzie, *Brit. Med. Jour.*

DOSIMETRIC THERAPEUTICS.—Dr. Burggraave, of Ghent, who is a declared enemy of the organic school of medicine, originated the above system of therapeutics—a system said to be founded on the "vitalism of Hippocrates." He based it on two laws. First, the being able to jugulate or cut short disease in its acute stage, and next the law of the "dominant" and "variable treatments"—the former acting on the cause of the malady and the latter removing the symptoms as they appeared. In chronic diseases both these treatments are required. This system is claimed to have the following advantages over pre-existing ones. First, it sustains the patient's vital powers from the time he is first brought under treatment; next, great weight is attached to minutiae and

the idiosyncrasies of individuals; and, lastly, the development of symptoms is not waited for, but the disease is cut short before any pathological lesions have had time to make their appearance.

Dr. Burggraave gives us to understand that in sufferers from traumatic fevers following operations, this idea of the jugulation of disease first dawned on him; that by means of the defervescent alkaloids (aconitine, veratrine and digitaline) he was able to arrest the fever; and by giving the nervines (phosphoric acid and sulphate of strychnine) check the progress of the inflammatory processes.

The medicines, which are given in the form of granules, contain varying quantities (from 1-130th to 1-6th grains) of the active substances, and are manufactured by M. Chas. Chanteaud, a Parisian chemist. These granules, when taken into the system, are quickly acted on by the gastric juice, and are easily assimilated; they undergo no chemical or physical changes, but in some way or other excite certain movements of nutrition known as the physiologico-catalytic. Medicines administered according to this method have an "elective action." Each drug attacking its special symptom, and in such a way as to soon re-establish the normal physiological condition. Great care is exercised in the manufacture of the dosemetric granules, especially in the preparation of the "Chanteaud Seidlitz," which is said to have marked advantages over ordinary purgatives, and is very largely used by the advocates of this system. In cutting short the inflammations of acute diseases it might be needful to administer several kinds of granules ever quarter or half hour, whereas in chronic cases fewer granules less frequently given will probably suffice—thus, in this system, acute diseases need an acute treatment, it being absolutely necessary to reach the curative stage as rapidly as possible; and chronic diseases require a chronic treatment. Take, for instance, a case of enteric fever. From the commencement of the attack a teaspoonful of the "Chanteaud Seidlitz" given every morning in a glass of water, clears the intestines of the fermenting nitrogenous matters, and considerably reduces the temperature. An enema, having the undermentioned composition (hydrate of chloral, 10 parts; borax, 5 parts; water, 250 parts) prevents diarrhoea and tenesmus, and acts both as a sedative and antiseptic. If the prostration is marked, and convulsions or muscular twitchings should also occur, a granule of phosphoric acid and strychnine every half-hour is needed. Should the temperature be high, a granule of aconitine and veratrine is to be given every half-hour, and should there be a marked difference between the morning and evening temperatures a granule of the hydro-ferrocyanate of quinine is required. A granule of morphine and hyoscyamine given every half-hour, until sedation of the symptoms, relieves the insomnia, restlessness, agitation and spasm. If the urine is scanty or depressed, digitaline and the arseniate of iron (a granule of each eight or ten times a day) must be given. If the patient sleeps well, and calm has been restored, promote digestion by giving two granules of quassine—three times a day—half an hour before food, and when the fever has ceased, six granules a day of the arseniate of soda is required.

In chronic phthisical cases check the paroxysmal fever by five or six granules of the arseniate of quinine, and the fever of consumption by the arseniate of caffeine (eight or ten granules a day). A granule each of iodoform and codeine relieves the fits of coughing, and one granule daily of quassine, half an hour before food, promotes digestion.

In cancerous cases, before the adoption of operative measures (Dr. Burggraave does not favor operations), the blood must be modified by the arseniates and iodides—if there is much engorgement, four to six granules a day of the arseniate of soda relieves this, and two granules of cicutine, night and morning, calms the lancinating pains. In cancerous cases specifics are useless, but the blood must be modified, since all cancers have their source in the red and white corpuscles, and the vital forces sustained by two granules of cicutine and the arseniate of strychnine in the evening, both of which substances act as modifiers and vital incitants.

The above, then, is a brief *résumé* of the dosemetric system of medication, and time alone will decide whether it should be placed on the same footing as the system adopted by the orthodox school of medicine.

If this system can jugulate acute disease, and does really oppose the appearance of the pathological lesions which bring about the various organic degenerations, it certainly deserves a fair trial at the hands of the medical fraternity.

—Geo. E. Claxton, *Hosp. Gazette*.

AN INQUIRY INTO THE RELATION THAT EXISTS BETWEEN MILD AND SEVERE FORMS OF SOME DISEASES.—In the different departments of science well-marked phenomena lead us to look for or infer the existence of less striking examples of the same or similar phenomena. Prof. Jevons, in his "Principles of Science" (p. 549), writes: "We must regard those changes which we can observe as the comparatively rare aggregates of minute changes. On a little reflection we must allow that no object known to us remains for two instants of exactly the same temperature. If so, the dimensions of objects must be in a perpetual state of variation." He quotes Prof. Tyndall as follows: "An upright iron stone influenced by the earth's magnetism becomes a magnet with its bottom a north and its top a south pole. Doubtless, though in an immensely feeble degree, every erect marble statue is a true diamagnet, with its head a north pole and its feet a south pole. The same is certainly true of man as he stands upon the earth's surface, for all the tissues of the human body are diamagnetic." He further illustrates this truth: "The sun's light produces a very quick and perceptible effect upon the photographic plate; in all probability it has a less effect upon a great variety of substances. We may regard every phenomenon as an exaggerated and conspicuous case of a process which is in infinitely numerous cases beyond the means of observation." We find the same truth unexemplified in physiology and pathology. Parturition has its minor manifestations in menstruation. Shelly wrote of "Death and his brother Sleep." The "oral whiff" is an exaggeration of the cardio-pneumatic impulses which can be detected in most, if not all, persons. Dr. Hughlings Jackson says: "A fit of epilepsy is an excessive caricature of the normal physiological process during what is called a voluntary action." Mr. Hutchinson has pointed out that rare diseases are sometimes exaggerated forms of what is common. There is a principle which governs the relation between mild and severe forms of some diseases, and which appears not to be recognized in medical writings. The principle is that some well-marked varieties of disease can only occur in communities where less marked varieties are not uncommon. If we find in a community rare cases of astigmatism of six dioptries, we are sure to find a large number

with less astigmatism. If we find more cases of severe myxœdema in women than men, we may conclude that milder forms of this disease are oftener found in women than men. The functional activity of the thyroid is greater in women. Complexity of function without corresponding complexity of structure practically lowers the level of evolution, and Dr. Hughlings Jackson has taught us that disease frequently first attacks the least organized parts. Hence the fact that women have myxœdema more than men, comes under the law of dissolution—the reverse of evolution.

To what diseases does the principle that the worst cases occur amongst those who suffer most frequently apply? It applies to diseases in which inherited predisposition plays an important part—*e. g.*, myxœdema, exophthalmic goitre, Raynaud's disease, etc. It holds good also where there is no marked inherited predisposition, as in myopia. In other cases there is no relationship between frequency and severity. A disease may be equally liable to occur in the two sexes or at any age, but owing to greater exposure to exciting causes one sex or persons of a certain age may suffer oftener. Infants have purulent ophthalmia less severely than adults and oftener. If this principle is not recognized error is likely to follow. A physician of great experience writes as follows: "If I may judge from my own experience, these rudimentary cases of Graves' disease are more common in men than in women. Men, as every one knows, are much less frequently affected with exophthalmic goitre than women, and it would appear (at all events as far as I can judge from my own experience) that when men do become affected with Graves' disease the clinical picture is apt to become imperfect." If the principle I have mentioned applies to exophthalmic goitre, it will be found that women suffer oftener than men from the mild as well as the severe forms. Von Graefe was probably in error when he said that exophthalmic goitre was more likely to be fatal in men. A distinguished ophthalmic surgeon writes that bad myopia is found oftener amongst hospital patients, while the benign form is found oftener amongst private patients. Mr. Priestley Smith has met this by statistics and arrived at a different conclusion—one that is quite in harmony with the principle I am discussing. The question as to the relation that exists between mild and severe myopia is rendered difficult by the fact that some cases of severe myopia differ etiologically from the milder cases. These cases are not, however, sufficiently numerous to vitiate the conclusion that the severest cases occur amongst those who suffer oftener.

Some difference of opinion exists as to whether mild cases of myopia and albuminuria are to be looked upon as physiological or pathological. It would be well to look on this question in the light of the principle that in communities where the mild forms often occur the severer forms are likely to occasionally crop up. It was thought that albuminuria occurring in association with acute infective diseases was sometimes due to high temperature. It is probable that many of these cases are really mild forms of parenchymatous nephritis due to the different poisons acting on the kidneys.

—Donaldson, *Lancet*.

DISCUSSION ON PUERPERAL ECLAMPSIA. — The discussion on Prof. Olshausen's valuable paper on Eclampsia, reported by me in your journal of the 13th ult., took place on January 20. Hr. H. Neumann

said that pathogenous bacteria had been found in the blood and in urine in patients dying from eclampsia. Hr. Olshausen had said that patients were prone to sepsis, but the speaker suspected that sepsis was already present in the anæmic condition, although not always demonstrable clinically. The infection did not need to be caused by any specific agent, it might depend on the retention of various pathogenic bacterial products. His views were supported by the results of prophylactic treatment, sweating, vivisection, purgatives, etc. Hr. Silex said that anæmic amaurosis was sudden at its onset, attacked both eyes, continued as a rule for some hours, and was always renewed by fresh attacks. Sometimes the pupil was dilated and rigid, sometimes it acted readily. The ophthalmoscope gave perfectly negative results. The prognosis was generally favorable. We had no certain conclusions as to anæmic amaurosis. Hr. Dührssen had during the last two years always delivered at once. In case the os was small he had incised it deeply. He had incised the cervix in 26 cases, delivered with forceps 21 times, turned and extracted with the forceps 3 times, and twice turned and extracted by the feet. All the mothers recovered, two children died. Besides two eclamptic cases already mentioned he had treated four other primiparæ in whom the os would only admit one finger. In the first case there had already been nine fits, the tenth was cut short by narcosis and operation at once performed. The second case lay in the deepest coma after a few attacks, with a pulse of 150. The third case was that of a woman, aged 44. The fourth commenced with amaurosis for which he was summoned. He saw the first attack. In all the cases delivery was effected in a few minutes, after which the fits and amaurosis ceased. Considering the dangers of eclampsia, and the cessation of the fits generally on emptying the uterus, this should be looked upon as the chief object. Even energetic measures so long as they were not dangerous to mother or child did not add to the danger. This was shown by Cæsarean section. In 11 cases in which it had been performed, the fits ceased in 10 on the uterus being emptied. Cæsarian section was, however, too dangerous an operation to be recommended. He would always recommend deep incision of the cervix, however, after the eighth month. Hr. Veit was not in favor of adopting Dührssen's practice. A great number of cases could not be treated by his method, for the cervix was already treated and the head low down. In the severest forms the attacks continued after the uterus was emptied. They ceased then only in the more favorable cases. There were cases again in which the attacks first came on after delivery and yet proved fatal. Eclampsia was so varied a condition that no uniform method of treatment would suit all cases. Hr. Bröse would adopt Dührssen's plan in severe cases but protested against employing it in all.

Prof. Virchow said that fat emboli were found in the great majority of cases in autopsies after eclampsia. In some there were in tolerably large quantities, as after fractures with crushing of the marrow of bones. It would only be ordinary fat. It was to be noted that bruising frequently took place in those parts that surrounded the uterus and pelvis, and arbitrarily called by gynæcologists "connective tissue;" "fatty tissue" would come somewhat nearer the actual condition. This fatty tissue, which during labor was exposed to a good deal of bruising, showed signs of it extensively at autopsies, therefore, the speaker thought that a not inconsiderable part of the fat found in the arteries and lungs appeared to spring from this

source. A second source was to be sought in the blows inflicted during the fits. He had never himself seen that fat passed in any quantities from the liver to the lungs. In those cases in which the liver was choke full of fat he had never seen fat emboli. It was also a question to be considered what other matters besides fat reached the liver. Jürgens indicated certain cells which he also found as liver cells. Careful investigations had been made into these in Birch-Hirschfeld's laboratory at Leipsic. It was there held to be proved that the epithelial layer of the placental sinus has become separated, carried into the lungs, and there filtered out, so that it was met with in the finer pulmonary vascular branches. He was not then in a position to give an opinion as to the extent of the process. He was not convinced that eclampsia was caused by it, and just as little that it was caused by fat emboli. The fat emboli were apparently a result of bruising inflicted during the fits. The pathological facts we possessed were in nowise sufficient to base a theory of origin of the fits upon, and so in regard to the changes in the kidney, changes which were met with in numberless other analogous diseases. There must be some other special cause which had hitherto eluded detection. He looked forward with interest to the newer investigations in regard to the changes in the blood itself. After an explanation by Hr. Dührssen, Prof. Olshausen replied. He said that Neumann's view of an infection by a micro-organism was untenable. If this was the case generally, indications of sepsis must manifest themselves in puerpera. But this was only exceptionally the case. The demonstrations of French authors were not free from objection. The micro-organisms were principally met with in excreted urine, and numerous other observers had met with negative results. He did not believe in this mode of origin of eclampsia. An attempt with Dührssen's method of treatment did not mean agreement with it. If the cervix was already dilated, and only a thin fold of os remained, this might be cut through without doing much harm, and the forceps could often be applied and the child extracted. He agreed that our treatment must be directed to shortening the labor, as this signified immediate, or early cessation of the attacks. In the cases mentioned the labor was frequently ended speedily and spontaneously. Generally labor was rapid, as the child was not carried to term. In such cases Dührssen's plan would often be of service. In cases in which the eclampsia appeared to him severe he would carry out the plan. He had never considered incisions into the cervix as dangerous, they were made thirty years ago. But big incisions through the whole of the vagina were dangerous, if forceps delivery was only possible with them he shrank from it. He gave the following case as an illustration: Six days before a case of eclampsia occurred; labor did not set in. He did not adopt Dührssen's procedure as the case seemed a mild one. But a prognosis in eclampsia was always very difficult to form. In this case the patient had no further attacks then and was delivered spontaneously ten hours afterward. She had a few afterward, but she seemed then to be convalescing. As regarded ætiology he thought it most probable the cause was an intoxication. The main cause of the origin of the fits was in the majority of cases a hindering of the renal secretion, whether the kidney was previously healthy, or whether affected by chronic nephritis. The whole course of the affection was in favor of this view, its acute onset, its rapid disappearance in the majority of cases.

—*Med. Press.*

OXYGEN AND STRYCHNINE IN RESPIRATORY TROUBLES.—In view of the importance of the subject, to which notice has been lately directed by Dr. Brunton and others, I would like to draw attention to an abstract of my M.D. thesis, published in the Liverpool *Medico-Chirurgical Journal* for July, 1888. In this I advocated the use of oxygen for the respiratory trouble of coma in all cases, and, amongst others, related a case of opium poisoning which occurred in July, 1885, and which I treated successfully with the inhalation of oxygen, after artificial respiration had been previously maintained for over six hours without, apparently, any permanent benefit to the patient.

As regards the case of pneumonia related by Drs. Brunton and Prickett in the *British Medical Journal* for January 23, in which venesection and the hypodermic injection of strychnine (apparently afterwards employed) failed to produce any marked effect, I may mention that in the case of opium poisoning referred to, dry cupping was resorted to over the chest and back, in order to relieve the extreme congestion of the head and neck; but it appeared to render the respiration more defective, and this was attributed to the withdrawal of blood from the circulation, diminishing its capacity for absorbing, and carrying oxygen when presented to it in a dilute form.

It is thus possible that in Drs. Brinton and Prickett's case the venesection was the cause of the respiratory center failing to respond to the hypodermic injection of strychnine, for in the following case of pneumonia a similar administration of this drug was followed by recovery.

M. B., a gentleman, aged about forty-two, had been going about suffering from symptoms resembling a mild attack of influenza, for five days, and when first seen, on December 15, 1890, presented signs of pneumonia, limited to a small area outside of the right nipple; this gradually extended until December 22, when the entire upper lobe had become involved. The temperature, with slight remissions, had been about 104° F., and there had been almost constant delirium since the evening of December 15; the mouth and fauces were inflamed and thickly dotted over with an aphthous exudation, and, on account of this and the dryness of the tongue, swallowing was extremely difficult, and for the last three days nutrient enemata had been employed. The patient being thus in a critical condition, Dr. T. D. Acland kindly saw the case with me in the evening of December 22, and gave a very gloomy prognosis. Dr. Sedgwick Saunders, who was attending from time to time in a friendly capacity, took a similar view of the case, although he was not able to be present at the consultation.

On December 24 I was called early to the patient, as it was supposed he was dying. On my arrival I found the friends firmly persuaded that the end was near at hand, one of the trained nurses having left with the impression that, such being the case, her services were no longer required. The condition of the patient was certainly alarming, for there had been several involuntary evacuations, enemata was no longer retained, there was retention of urine, and it seemed almost impossible to get him to swallow. He was quite unconscious, with teeth tightly clenched and face very dusky, constant twitching about the mouth, and convulsive movements of all the limbs. The respirations were slow and of a marked Cheyne-Stokes character, with long pauses at intervals, during which the patient became much cyanosed, and was on several occasions supposed, by the friends, to have breathed his last. There being no time to ob-

tain a supply of oxygen, which I have successfully used on other and somewhat similar occasions, I concluded the best thing to do was to stimulate, if possible, the respiratory center, to the exhaustion of which the urgency of the symptoms appeared to be mainly due. I therefore obtained a solution of strychnine, and gave a hypodermic injection of $\frac{1}{80}$ of a grain; a slight improvement soon took place in the breathing, and I was encouraged to repeat the injection after a short time, and at intervals of a few hours, until I had given the $\frac{1}{10}$ of a grain. By this time the respiration had become quite regular, and consciousness had returned. The patient subsequently made a complete recovery.

I should mention that the case was complicated by a severe burn on the chest, caused by the application of a poultice on December 17. This was an additional indication for the use of oxygen, could it have been obtained in time, for the gas has been shown to be of marked utility in cases of extensive burns.—Couper Cripps, *Brit. Med. Jour.*

GERMAN NOTES.

HERMAN D. MARCUS, M.D.,
Resident Physician at the Philadelphia Hospital.

THE USE OF VASELINE IN CATHETERISM.—Dr. Hovotny in *Budapest* cautions against the use of vaseline for anointing catheters. He has observed that the vaseline thus introduced into the bladder changes, owing to its insolubility, into mass, which causes a urinary deposit on it. In one case the amount of detritus thus formed was 150 grains.—*Deutsche Med. Zeitung.*

TREATMENT OF DIPHTHERIA.—Dr. Jacob Munk (*Duna-Szerdahely*) recommends the following treatment:

Besides local applications of ice and suitable diet (Cognac alone or in milk), painting of the larynx three times daily with following solution:

R.—Creolin puriss (Pearson)..... gr. xv-xxx.
Aque..... gr. 150.

This solution is used by dipping a piece of wood wrapped in cotton in the fluid and cleansing with it the adherent grayish white diphtheritic membrane. Munk has never seen any ill results if the patient happened to swallow some of the fluid. By such procedure the deposits became smaller and smaller, until finally on the third day there are only a few points visible on the tonsils, and the patient regains his normal temperature, providing the treatment was begun as soon as the disease was recognized. Munk has never lost a case when employing such treatment.

—*Internat. Klin. Rundschau.*

SPECIFIC GRAVITY OF THE BLOOD IN DISEASE.—Dr. Hammerschlag draws the following conclusions after a number of examinations of the blood:

1. The specific gravity of the blood depends generally on its amount of hæmoglobin, and is entirely independent of the number of blood corpuscles present.

2. In chlorosis, anæmia, tuberculous diseases and malignant tumors there is always a constant relation between the amount of hæmoglobin and the specific gravity, inasmuch as a certain amount of hæmoglobin causes in different patients the same specific gravity. It is therefore possible to draw conclusions on the amount of the coloring matter in the blood, and it suffices to ascertain the specific gravity of the blood to decide the state of disease.

3. In nephritis it is found that the specific gravity of the blood is lower than the amount of hæmoglobin would indicate.

4. In circulatory disturbances the specific gravity remains generally normal, even if oedema is present.

5. In fever the specific gravity decreases, but becomes normal on defervescence.—*Centralblatt für Klin. Medizin.*

IODOL AND ANTIFEBRIN IN CEREBRO-SPINAL MENINGITIS.—Dr. Strisower recommends the combination of equal parts of iodol and antifebrin in two cases (four-year-old girl and thirteen month-old boy). Three doses, of 1-grain each of the combination were sufficient to cause defervescence and quick recovery. Strisower also tried the mixture in summer diarrhoea of children, and found two or three doses sufficient to stop the vomiting and relieve the restlessness and thirst.—*Allg. Med. Centr. Zeitung.*

SUPPOSITORIES IN CHRONIC PROSTATITIS.—Oberlaender recommends the following suppositories:

R.—Iodoformi..... gr. viiss-xv.

Solve in—

Ol. amygdal. dulc..... q. s.

Add—

Butyr. cacao q. s.

U. f. supposit. No. x.

Sig.—Every evening, after previous evacuation, use 1 suppository.

Ol. amygdal. dulc. helps to absorb the iodoform. It is well to start with $\frac{3}{4}$ -grain doses, and gradually rise to 1½ grains; 1½ grains may cause in some patients toxic symptoms, but small doses are always well borne.—*Deutsche Med. Wochenschrift.*

FRENCH NOTES.

A. E. ROUSSEL, M. D.

ON ACCUMULATION OF BROMIDE OF POTASSIUM IN THE NERVOUS CENTERS.—At the Société de Biologie, MM. Féré and Herbert reported their experiments on the accumulation of bromide of potassium in the organism, and particularly in the nervous centers. The peripheral nerves contain this salt in marked quantities, but it is especially in the cerebellum that the accumulation is most noticed.

—*Le Progrès Médicale.*

THE TRANSMISSIBILITY OF CANCER.—MM. Duplay and Cazin, after numerous experiments, arrived at the following conclusions: That cancer is not transmissible from man to animals, or from one animal to an animal of a different species. As regards the transmissibility from an animal to another of the same kind, the authors are not prepared to advance a definite opinion.—*La Médecine Moderne.*

TREATMENT OF HICCOUGH BY PRESSURE OF THE PHRENIC NERVE (Leloir).—A young girl of twelve years of age had suffered for the past year from an incurable hiccough, occurring every half minute. Pressure was made upon the left phrenic nerve for a period of three minutes, with a total disposition of the trouble. M. Leloir has since applied this method to a great number of both acute and chronic cases with invariably good results.—*La France Médicale.*

THE ADVENT OF THE "PORE-PLASTER" IN FRANCE.—We notice that at a recent meeting of the Société de Thérapeutique, M. C. Paul calls to the attention of the society the advantages offered by the use of the American porous plaster, and mentions that it has recently been manufactured by different pharmacists.

Medical News and Miscellany.

IN PREPARATION.—A special number devoted to inebriety and its treatment.

DR. W. D. BIDWELL, of Washington, D. C., has gone to Aiken, S. C., on account of serious pulmonary symptoms.

WE need for our files two copies of THE TIMES AND REGISTER for January 30, 1892, and will be glad to recompense any of our readers who will send us a copy of that date.

THE students of Rush Medical College issue a monthly journal during the college year known as *The Corpuscle*, devoted to matter connected with their college. We congratulate the boys on the number before us.

Two prominent young men of Healdsburg have been arrested for burglarizing the drug store of Jones & Hobson, taking therefrom a few dollars in change and a bottle of whiskey.—*Pacific Drug Review*.

If they'd only taken the whiskey and let the money alone, no sympathizing jury would have convicted them.

DR. CONSTANTINE PAUL'S new development of Brown-Séquard's principle has been received with such universal condemnation that one begins to think there is something in it. All genuine discoveries in medicine are met with incredulity and opposition, while only Koch's lymph, and such, evoke the instant and universal enthusiasm of the medical profession.

THERE were only twenty-eight deaths from typhoid fever in Chicago the last week in February, a decrease of nearly one hundred per cent. from the preceding week, when a record of fifty-two deaths was itself a marked decrease from the week preceding. Health Commissioner Ware is confident that the month of March will show a continued diminution in the number of deaths.

IN nothing is Chicago behind the rest of the world. It has its post-graduate school, its Pasteur institute, its World's Fair, its three homœopathic colleges, and at last it is supplied with an agency for the sale of the only genuine "Electro-Homœopathic Remedies." Count Cesare Mattei has invaded the *Urbs in Horto*. Here, at the "only agency in the United States," can be obtained the Count's famous preparations.—*Med. Era*.

PROPHYLAXIS OF AFRICAN FEVER.—At Blantyre, a Scottish settlement and mission near Lake Nyasa, in Central Africa, there is published a little paper called *Mission Life and Work*. In an article referring to the ravages of malarial fevers along the common routes of travel—almost wholly by water ways—the following statement is made: "Twelve grains of quinine with five drops of eucalyptus oil have been taken every third day during a journey lasting three weeks, from Quilimane, at the mouth of the Zambesi, up into the Lake Country; no fever developed at that time or since." The writer believes that the immunity was obtained by this combination of the oil of eucalyptus with quinine, taken at regular intervals. As an antimalarial combination, in districts where quinine alone does not suffice, this suggestion seems worthy of trial precisely as proposed. If any of our readers see fit to make a trial of it, will they kindly notify us of their results?—*Jour. Am. Med. Assoc.*

THE Managers of the Seaside House for Invalid Women desire to invite the attention of clergymen and physicians to the advantages offered to poor sick women by the Mercer Memorial House at Atlantic City. In it, a comfortably furnished private room, with board, nursing, medical treatment, and medicines can be had for four dollars per week, or about one-half the actual cost. Circulars can be had by writing for them to the Mercer Memorial House, Ohio and Pacific avenues, Atlantic City, N. J. No one is ever admitted without previous application. The house will be open in 1892, from March 23 to October 1.

THE eleventh annual meeting of the N. C. O. Medical Society will be held at Mansfield, Ohio, Friday, March 25, 1892. The following papers are announced: President's Address, R. Harvey Reed.

"Constipation—Its Causes, Consequences and Treatment," Geo. P. Sattler, M.D., Pavonia, Ohio.

"Diphtheria—Etiology," A. V. Patterson, Mansfield, Ohio.

"Diphtheria—Treatment," H. B. Gibbon, M.D., Tiffin, Ohio.

"Differential Diagnosis Between Croupous and Diphtheritic Membranes," J. W. Craig, M.D., Mansfield, Ohio.

To open discussion, F. C. Larimore, Mt. Vernon, Ohio.

AN examination for the position of resident physician in the Methodist Episcopal Hospital of Philadelphia will be held on Tuesday, March 29, 1892, at the Hospital, Broad and Wolfe streets, Philadelphia, at 8 P.M.

The examination is open to both men and women, but applicants must, in accordance with the charter of the hospital, have the degree of Bachelor of Arts. Two residents will be selected by the trustees from the candidates who obtain the first four places in the examinations by the Medical Board.

Applications to be made to Dr. John B. Roberts, 1627 Walnut street; Dr. Richard C. Norris, 1028 Spruce street; Dr. Wm. C. Hollepeter, 1408 North Thirteenth street; Dr. H. H. Kynett, 1728 Spring Garden street.

CHICAGOISMS.—Our junior students are so zealous in their anatomical studies that they walk through the streets in broad daylight carrying bones of all sizes and descriptions. This is hardly the proper thing to do, for a piece of paper wrapped around the bone would not be much trouble to the student, and the public eye would certainly look with more favor on such a package.

One of the professors of the Woman's Medical College told the fair damsels who listen to his lectures, that a Rush man wrote in an examination that two of the signs of physical diagnosis were osculation and palpitation. Probably the student who gave the above answer had just learned the fact that the latter sign was a frequent sequence to the osculatory act when the kiss was given to a pretty girl.

—*The Corpuscle*.

THE SCARLATINA NUMBER.—Copies of the Scarlatina Number will be sent on receipt of ten cents. No free samples of the special numbers will be given away. The Scarlatina Number contains five original articles, one editorial, one annotation, fifteen letters, and nine selected articles, all upon Scarlatina; besides a list of all the articles on this subject printed in 1891. In the Digest there are nineteen prescrip-

WEEKLY Report of Interments in Philadelphia,
from March 5 to March 12, 1892 :

MONTHLY BULLETIN OF THE NEW YORK STATE BOARD OF HEALTH.—The mortality of January is greater than that of any month previously recorded except that of April, 1891, which it nearly equals. It arose from a daily average of 291 deaths in November, of 362 in December, to one of 434, exceeding the daily average of January, 1891, by 126 deaths, and that of the entire year 1891 by about 100 deaths. The increase is due to epidemic influenza, what may be termed the third outbreak of which reached its height during this month. Compared with January, 1890, and April, 1891, the two months of the height of previous epidemics, the mortality in early life is less, while that of old age seems to be much greater; from acute respiratory diseases, and also from consumption, the number of deaths is considerably less than in either of the other months. Deaths attributed to diseases of the digestive and circulatory systems are increased. Compared with previous outbreaks, this one has appeared to fall especially upon the aged, the

"The barren and inhospitable valleys of Freissinières and Dormilhouse have gradually become unin-

habitable. The climate has become much colder, the perpetual snows and glaciers are invading the once fertile slopes. The soil is covered with a thick coat of snow for nine months in the year. Landslides and avalanches destroy hamlets and fields, killing men and cattle; and those sturdy Vaudois are fighting an unequal and desperate fight against nature itself, and are disappearing gradually by starvation, expatriation or accidents."

The "Société Coligny" is now appealing for funds to enable these estimable people to remove *en masse* to Algeria, where already several bands have founded flourishing settlements. Contributions to this worthy object may be forwarded to Messrs. Iselin & Co., bankers, New York City; Rev. T. D. Malan, editor of *Il Roma*, Philadelphia; or to M. D'Allens, Treasurer of the Société Coligny, 29 Rue Taitbout, Paris, France.

THE Belgian Society of Gynecology and Obstetrics, under the patronage of the Belgian Government, has taken the initiative in organizing "The International Periodical Congress of Gynecology and Obstetrics," the first session of which will be held in Brussels, September 14 to 19, inclusive, 1892. Three leading questions will be offered for discussion:

1. "Pelvic Suppuration;" referee, Dr. Paul Segond, Paris.
2. "Extra Uterine Pregnancy;" referee, Dr. A. Martin, Berlin.
3. "Placenta Prævia;" referee, Dr. Berry Hart, Edinburgh.

Fees: Members participating in first session, thirty francs. (This will entitle the holder to a copy of the proceedings of the Congress). Founders (life membership), three hundred francs.

In connection with the Congress there will be an International Exposition of instruments and appliances, pertaining to gynecology and obstetrics.

All communications pertaining to this Congress should be mailed direct to the American Secretary, who will promptly furnish all information. All notifications to be forwarded should be received by August 1.

Everything points to a great success in this Congress. Though notices concerning it have been rather late in this country, already men of celebrity have promised to visit and contribute papers. Among the many foreigners who have written to the Sec. Gen., endorsing and promising support to the undertaking, may be mentioned the following eminent men:

Belgium.—De Roubaix, Sacre, Mirriar, Pigeolot, Charles, Sanpart, and others.

France.—Pean, Demous, Fochier, Auvard, Doleris, Pozzi, Tarnier, Budin, Terrillon, Terrier, and others.

England.—Lawson Tait, Wm. Priestly, Champneys, G. Elder, J. White, Watt Black, Thornton, Doran, Spencer Wells, Bantock, and others.

Germany.—Martin, Leopold, Sanger, Gusserow, Veit, Winchel, Hegar, Kaltenbach, Freund, Heyder, and others.

Switzerland.—Reverdin, Vuillet.

Russia.—Slaviansky.

Sweden.—Saliss, Westernark.

Norway.—Statfeldt, Howitz, Meyer.

Italy.—Porro, La Torre, Mangiazalli, Bozzi, Morisain.

Turkey.—Chatazian.

Holland.—Stokvis, Treub, Nyhoff.

Austria.—Pawlik, Albert, Chrobuk.

Finland.—Engstrom, Heinrichus, Pippingohold.

Further details will be furnished as soon as received.

A PRETENDER.

BERLIN, February 11, 1892.

DR. SIMON BARUCH.

Dear Sir:—In some of the American lay journals, especially in Cincinnati, the following misuse is made of the name of Virchow.

In these papers is an announcement that the great German physician, Dr. Karl Virchow Schick, just arrived from Germany, is prepared to give consultations. He claims to have made important discoveries in the germ treatment of chronic diseases, and that his prescription is used by eight hundred and six physicians of Europe.

In the official register no physician of this name is to be found in Berlin or Germany.

The intention of the man is evidently to mislead the great public by means of the name Virchow.

I would request you, honored colleague, to have this letter published in order to protect the public against imposition. Yours truly,

[Translation.] DR. S. GUTTMANN,
Editor of Deutsche Med. Wochenschrift.

Army, Navy & Marine Hospital Service.

Changes in the Medical Corps of the U. S. Navy for the two weeks ending March 12, 1892.

BRUSH, GEO. R., Medical Inspector. Ordered to Navy Yard, Brooklyn, N. Y.

KERSHNER, EDW., Medical Inspector. From Navy Yard, New York, and to U. S. S. "San Francisco."

CLARK, J. H., Medical Inspector. From the U. S. S. "San Francisco," and ordered home.

GHON, A. L., Medical Director. Detached from Naval Hospital, and to special duty at New York, attending officers of the Navy and Marine Corps.

SCOFFIELD, W. K., Medical Director. Detached from special duty at New York, attending officers of Navy and Marine Corps, and wait orders.

BOGERT, E. S., Medical Director. Detached from Medical Examining Board, and to Naval Hospital, Brooklyn, N. Y.

DE VALIN, C. M., Assistant-Surgeon. To Naval Hospital, Norfolk, Va.

BRATHWAITE, F. B., Assistant-Surgeon. From Hospital Chelsea, and to the U. S. S. "Fern."

GATES, M. F., Assistant-Surgeon. From the U. S. S. "Fern," and granted two months' leave.

LA MOTTE, HENRY, Assistant-Surgeon. Ordered to the U. S. Receiving Ship "Vermont," at New York.

VON WEDEKIND, L. L., Assistant-Surgeon. From the U. S. S. "Vermont," and granted three months' leave.

KERSHNER, E., Medical Inspector. Orders to the U. S. S. "San Francisco" revoked.

VAN REIPPEN, WM. K., Medical Inspector. Detached as assistant to Bureau of Medicine and Surgery, and to the U. S. S. "San Francisco."

GATEWOOD, J. D., Passed Assistant-Surgeon. Ordered to the U. S. S. "Dolphin."

STITT, E. R., Assistant-Surgeon. Ordered to the Naval Hospital, Philadelphia, Pa.

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"E. L. BETTERLY, M.D.,

"Physician in Chief, Wilkes-Barre, Pa., Small-Pox Hospital."



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Journal of the American Medical Association, Chicago, Ill.

DR. S. POTTS EAGLETON, Resident Physician in the Children's Hospital of Philadelphia. "Résumé
—Hydrogen Peroxide in Surgical Affections." *Medical and Surgical Reporter*, Philadelphia, Pa.

NOTE.—Avoid substitutes—in shape of the commercial article bottled—unfit and unsafe to use as a medicine.

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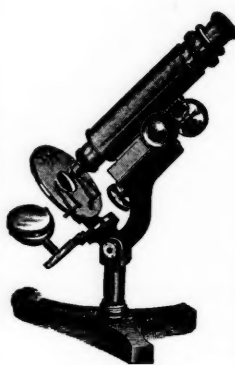
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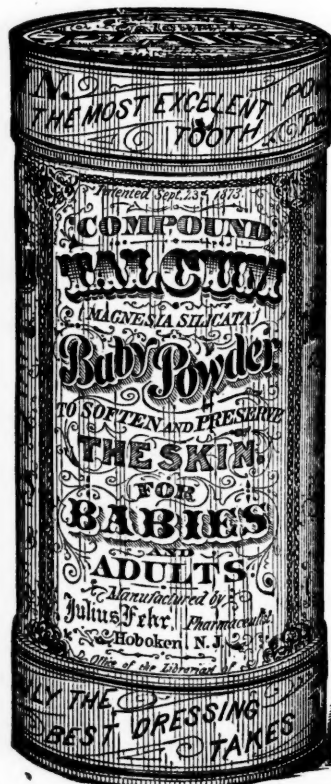
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